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STUDY TITLE

**Needing permission:
The experience of self-care and self-compassion in
nursing**

AUTHOR

HANNAH ANDREWS

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DECLARATION

This thesis submitted to the University of Warwick is my own work and has not been submitted for any previous degree at any other university.

GLOSSARY OF TERMS

Band 5	Staff Nurse
Band 6	Deputy Manager / Sister
Band 7	Ward Manager
Band 8a – 8b	Senior Management / Executive Team
CAMHS	Child and Adolescent Mental Health Service
CFT	Compassion Focused Therapy
CM	Compassion Meditation
DQ	Dual Qualified
LKM	Loving Kindness Meditation
NHS	National Health Service
NMC	Nursing and Midwifery Council
RGN	Registered General Nurse
RM	Registered Midwife
RMN	Registered Mental Health Nurse
RNC	Registered Children and Young Peoples Nurse
RNMH	Registered Nurse Mental Health / Learning Disabilities
USA	United States of America

ABSTRACT

In the National Health Service (NHS) there appears to be a culture of substantial change, with many nurses highlighting the impact of this on their own wellbeing (BPS, 2014). Reports following negative healthcare experiences, such as those reported at Mid Staffordshire (Francis, 2013), led to a number of initiatives emphasising the importance of nurses delivering compassionate care. However, there is a dearth of literature focusing on how nurses care for themselves as they try to provide compassionate care in a challenging job within a climate of constant change. The literature places a focus on the more negative aspects associated with providing care such as compassion fatigue, burnout and vicarious traumatisation, rather than on nurse's ability to look after themselves through self-care and self-compassion.

The purpose of this study is to focus on experiences of self-care and self-compassion in nursing and how these experiences may relate to compassionate care giving. Constructivist Grounded Theory was used, and purposive and theoretical sampling were utilised to recruit nurses working within two NHS Trusts in the UK. Semi structured interviews were undertaken with 30 nurses from general, mental health and learning disabilities and at different levels of seniority.

Data analysis was conducted in line with the Constructivist Grounded Theory approach as suggested by Charmaz (2014) and resulted in the emergence and construction of three concepts: 1) 'Hardwired to be caregivers' – vocation versus role 2) Needing a stable base and; 3) Managing the emotions of caring. All three concepts were then linked with a core process: needing permission to self-care and be self-compassionate. Nurses needed permission from others and from themselves in order to be self-caring and self-compassionate. An inability to do this appeared to impact upon their own wellbeing and compassionate care giving to others.

Nurses in this study described how they struggled particularly with self-compassion. Helping nurses to be proactively more self-caring and self-compassionate may increase their ability to manage emotions and prevent some of the more negative consequences of nursing such as burnout and compassion fatigue. Participants identified that if they had formal permission (e.g. within nursing guidance) to look after themselves then they would be more likely to engage in it and benefit from self-care and self-compassion. Future research within this field is recommended in order to gain an understanding of the effects of self-care and self-compassion initiatives.

CHAPTER 1

INTRODUCTION

1.1 – Introduction to chapter:

How nurses care for themselves within the context of the nursing profession is rarely written about, with the literature often instead placing a focus on compassionate care giving towards patients, and on perceived more difficult aspects associated with nursing such as emotional labour, burnout, compassion fatigue and vicarious traumatisation. This thesis sets out to systematically address the gap in understanding around the experience of self-care and self-compassion within nursing and how this relates to compassionate care giving.

This chapter provides background information and introduces the study. The area of interest is outlined and my own background is discussed to show how the research topic and questions were identified. The research aims and objectives, including the research questions, are outlined along with an overview of the study methodology chosen. An outline of the thesis structure is then presented.

1.2 – Preface to the study

I have been a nurse for the past 19 years, working in a variety of settings within the NHS and the private sector, including acute psychiatry, psychiatric intensive care, child and adolescent mental health (CAMHS) and specialist services (Eating Disorders). Throughout my career I have observed growing pressures, changing services and restructuring, increasing targets, reducing resources and the impact this is having on nursing staff, with some more than others being affected. This has caused me to reflect on how nurses care for themselves in this climate of change and why some nurses may struggle more than others in applying self-care and looking after themselves. Compassion is also a very current concept, often associated within NHS trust values, legislation and patient research but how is compassion applied to the self? Is there a need to apply it to the self and what is the relationship between self-care, self-compassion and compassionate care giving?

As a nurse, I endeavor to keep up to date with knowledge and ensure my practice is grounded in evidence. However, throughout my career I have always thought what must it be like to be a part of the evidence building and be actively involved in research. In 2010 I successfully interviewed for a research mentorship programme run by the Comprehensive Local Research Network (CLRN) - West Midlands South, and as a result of this I was able to complete a Masters by Research focusing on a Compassion Focused Therapy approach in treating low weight eating disordered patients. This utilised a quantitative design with six patients and followed their progress over a period of eighteen months. Whilst this was not directly related to the current study, it opened my eyes to research and gave me an understanding of the role of a nurse researcher. Throughout the period of study I decided I wanted to continue to be involved in further research and to explore qualitative methodologies in order to gain a sense of participant experience. This research experience, combined with my interest in self-care and self-compassion within nursing, gave me the confidence to embark on this PhD journey and current research study.

1.3 – Setting the scene:

In the National Health Service (NHS) there has been a culture of substantial change, with many nurses highlighting the impact this has had on their own physical, psychological and emotional wellbeing (British Psychological Society (BPS), 2014; Leininger & McFarland, 2006; Rose & Glass, 2006). Changes sometimes happen following negative healthcare experiences such as the crisis at Mid Staffordshire (Francis, 2013), Winterbourne View (Bubb, 2014), Morecambe Bay (Kirkup, 2015) and the Confidential Inquiry into the Premature Deaths of people with learning disabilities (CIPOLD, DoH, 2013). Government White papers also place a focus on change management, striving for a more efficient and robust NHS. Whilst some documents highlight the need to make vast economic savings (DoH, 2011), others emphasise the importance of compassionate and quality care for patients (DoH, 2013), highlighting a tension between cost savings and the needs of patients.

The term compassion and the concept of compassionate care have been embedded within local and national policy (DoH, 2009; DoH, 2012; NMC,

2015), encouraging compassionate care giving. However, there has been a striking absence of research and initiatives that address whether nurses can or do care for themselves. The literature suggests that more focus should be given to a nurse's own ability to be self-caring and self-compassionate and to measure the impact of this on care giving to others (Richards, 2013; Mills & Fraser, 2014). Nurses are continuously exposed to difficult situations, such as death, illness, deterioration, and ethical dilemmas, which can lead to distress and conflicted feelings (Davidhizar, 1993; McAllister & McKinnon, 2009), reinforcing the need for research within the field of self-care, and management of emotions in order to self protect, process emotions and increase resilience (Skovholt & Trotter-Mathison, 2011). The ability to be self-caring and self-compassionate may then impact on levels of compassion fatigue, burnout, vicarious traumatisation and improve staff retention, staff engagement, resilience, ability to offer compassionate care and job satisfaction (Maslach, 2003; Sabin-Farrell & Turpin, 2003; Dominguez-Gomez et al, 2009; Newall & MacNeil, 2010, Elwood et al, 2011 & Abaci & Arda, 2013).

1.4 – Research questions:

The aim of the research is to fill the research gap in gaining an understanding around self-care and self-compassion by interviewing nurses, in order to provide an original contribution to knowledge within this field. The following broad questions guided the research study:

- What are nurses' experiences of self-care and self-compassion?
- How do these experiences relate to compassionate care giving?

1.5 – Overview of the research:

This study explored nurses' personal experiences of self-care and self-compassion in practice. Through a combination of in-depth interviews with nurses across the general, mental health and learning disabilities disciplines, reflexivity and constant comparison, findings were used to develop a conceptual framework for use within nursing education, nursing guidance, nursing policy and nursing practice.

1.6 – Grounded Theory Methodology:

A constructivist grounded theory approach was adopted for this study and was guided by the work of Charmaz (2014). Qualitative data were collected, transcribed and analysed concurrently in order that early findings could aid in directing further sampling and flexibility in interviewing, allowing the process of exploring key issues and following up leads within the data. Data collection and analysis using this methodological approach took approximately twelve months to complete. Interview transcripts were coded using the process outlined by Charmaz (2014) to aid description within the data and to identify what was happening. A constant comparison method was utilised within the analysis in order to constantly compare the data back and forth within transcripts, between participants, between different nursing disciplines and between participants with different years of experience. This process ensured the close alignment of the constructivist grounded theory methodology and enabled the identification of key concepts and the construction of the core process, as outlined within the findings chapter.

1.7 – Timeframe and thesis structure:

I commenced my PhD at the Royal College of Nursing Research Institute in September 2014. Data collection took place between September 2015 and March 2016.

Chapter 1 - Introduction: This chapter introduces my background, and sets the scene by including a brief synopsis of the literature, providing a rationale for the study, outlining the research questions, providing a brief summary of the methodology used and clearly outlining the structure of the thesis.

Chapter 2 - Literature Review: This chapter explores the literature relating to the field of interest in order to identify the gap in knowledge and provide a rationale for the study carried out. The literature review initially focused on my starting assumptions and a structured account of my search strategy used to identify the body of literature used to critically examine my initial assumptions and opening ideas. The subsequent sections then present a critical in-depth analysis of the key findings in order to critically discuss the key themes and delve into the

complexity of the topic. The literature was initially reviewed prior to commencement of the study and then continuously reviewed throughout the period of the doctoral programme to ensure a current understanding of the knowledge was maintained. There is much debate regarding the timing of the literature review within a grounded theory study and this is further discussed in Chapter 3.

Chapter 3 - Methodology and Methods: This chapter provides a detailed account of the methodological approach chosen and the methods used. It commences with an exploration of my philosophical stance and the constructivist paradigm chosen. It explores different qualitative approaches including phenomenology and ethnography before providing a rationale for choosing constructivist grounded theory (Charmaz, 2014). It also provides background information pertaining to Grounded Theory from its inception through to its varied history, placing a focus on the key developments and the resultant variations in its approach. The chapter then provides a step-by-step account of methods applied, showing a close alignment with the methodological approach chosen.

Chapter 4 - Study Findings:

The study findings are presented as three initial concepts; ‘Hardwired to be caregivers’- vocation versus role; needing a stable base and; managing the emotions of caring. They are all connected by the core process; needing permission to self-care and be self-compassionate. These findings are illustrated throughout with verbatim quotations from the participants. The chapter concludes with a conceptual framework that encapsulates the findings.

Chapter 5 - Discussion:

Chapter five presents the discussion, reflections, conclusions and future recommendations and is presented in two parts. Part one provides a discussion of the research findings within the context of the current literature alongside the utility of the conceptual framework relating to the core process; ‘*Needing Permission to self-care and be self-compassionate*’.

Part two of the chapter provides a focus on my study reflections, the strengths

and limitations of the study, conclusions and recommendations for future research.

1.8 – Summary

This chapter has provided background information relating to my own experience as a nurse and researcher and has identified how the phenomenon of interest and research ideas for this study arose. It has detailed the structure of this thesis and the content of each chapter.

Chapter 2 provides a review of the literature, which sets out to identify and critically review the current literature and evidence base and the current gaps in knowledge, and provide justification for the need for this research study.

Chapter 2

The Literature Review

In chapter 1 I outlined my interest in understanding nursing perceptions and experiences of self-compassion and self-care and how these experiences may relate to compassionate care giving. I have identified Constructivist Grounded Theory as the approach I propose to use to explore nursing perceptions and to gain a theoretical understanding of this area of interest. In this chapter, in keeping with Constructivist Grounded Theory Methodology, I describe a critical discussion of the literature. It was undertaken to examine existing ideas and concepts in this area, to sensitise me and thus help me explore in greater depth with my participants their experiences of these ideas and concepts and how they may sit and relate to existing knowledge. The literature review will establish what is known, what is missing and thus enable me to justify my research.

2.1 – Introduction

Within healthcare there has been a culture of substantial change; nurses recognise the impact of this change on their physical, psychological and emotional wellbeing, which can impact upon patient outcomes (British Psychological Society, BPS, 2014; Leininger & McFarland, 2006 & Rose & Glass, 2006). This can impact upon patient outcomes, in part due to the detrimental effects of stress on compassion and social connectedness (Fogarty et al, 1999; Kim et al, 2004; Del Canale et al, 2012). Thus as noted by Seppala et al (2014), stress not only affects the health and psychological wellbeing of clinical staff, including nurses, but also directly impacts upon the quality of care provided to patients.

Increasing compassion for one's self and others is thought to decrease stress, improve staff wellbeing and positively impact patient care (Lamothe et al, 2014), whilst also maintaining organisational commitment (Lilius et al, 2008). This possibility of addressing stress faced by healthcare professionals, coupled with my own observations of growing pressures and experiences as a nurse, led to an interest in how nurses care for themselves and whether this links to the compassion with which they can care for others.

My starting assumptions were thus - that nurses are under increasing pressure to deliver care and meet targets in this culture of substantial change, resulting in increasing levels of stress, burnout and nurses leaving the profession. It is unclear whether nurses can utilise self-care and self-compassion when facing these pressures in order to deal with their own internal processes and emotions or to cope with the environment in which they work. Recent examples within the NHS in which compassionate care appeared to be lacking (DoH, 2013; Francis, 2013; Bubb, 2014; Kirkup, 2015), together with concerns over how nurses deal with constant changes and pressure, made me question whether nurses' ability to be caring and compassionate towards the self affects their own ability to be compassionate towards patients and deliver compassionate care.

2.2 – Aims of the literature review

The aim of this review was to provide a critical discussion of the literature relevant to the present study. It incorporates discussion and opinion pieces alongside broader literature due to a lack of empirical work in this area.

Nurses as a group are often linked to compassion within the existing healthcare literature, highlighting their close association with compassionate care (Bivins et al, 2017). They spend large amounts of time with patients, and are involved in basic and complex (sometimes intimate) care processes, requiring them to actively engage and collaborate in all aspects of the patient journey. In practice nurses deal with multiple stressors simultaneously, in increasingly complex environments (Crary, 2013). Due to this I will argue that there is a need to look at how self-care and self-compassion are experienced from a nursing perspective and how this relates to and may influence the provision of compassionate care for others. This literature review explores what is already known about this field of interest and provides a rationale for the research I conducted.

The literature was reviewed in two phases. Initially, prior to designing the study, situating the phenomena of interest within the context of existing knowledge, identifying and defining key terms and processes within healthcare, identifying gaps within the evidence base and supporting the need for further study and justification of my own proposed research. Secondly, once the study was

designed, in line with constructivist Grounded Theory Methodology (See chapter 3, section 3.26), the literature was re-examined iteratively throughout the process of analysis to aid theoretical coding, identify more recent studies, explore leads within the data and to ensure constant comparisons were maintained (further explored in chapter 3).

2.3 – Literature review methodology

The approach used to conduct this literature review is presented as two sections; search strategy (2.3.1) and the selection and assessment of studies (2.3.2).

2.3.1- Literature Search Strategy

This section covers how the literature search was conducted and includes data sources, search terms and the inclusion and exclusion criteria.

I) – Data sources

A search was conducted in the following databases: Medline, EBSCOhost, Cinahl, Psychinfo, ASSIA, Cochrane, Embase and Pubmed, using key terms. Searches were also undertaken, using free text and MeSH headings, in Web of Science, Science Direct and NHS Evidence and certain Internet search engines such as Google Scholar. The grey literature was searched via Internet search engines and included conference papers, posters and theses (See Appendix 1 for the literature search strategy). Organisational websites were also searched for further publications of relevance (see table 1).

Table 1: Organisational websites

Organisation	Website
Royal College of Nursing (RCN)	https://www.rcn.org.uk
Nursing and Midwifery Council (NMC)	https://www.nmc.org.uk
Department of Health (DoH)	https://www.gov.uk/government/organisations/department-of-health-and-social-care
British Psychological Society (BPS)	https://www.bps.org.uk
Health & Care Professions Council (HCPC)	http://hcpc-uk.org

The aim was to target key databases and alternative sources (as stipulated above) to identify key knowledge within the field of interest.

II) – Search Terms

The literature review focuses on the key concepts within this thesis; the nature of compassion and how it sits within the context of nursing; the self-compassion and self-care literature, critically examining what is known about these topics and how they are presented and viewed within nursing and; compassionate care giving, including how this is defined and what is currently known and not known about how it relates to the other concepts within the literature base. Search terms were generated from the research questions and an initial exploration of texts on the topic, looking at the key words used and then building upon this. I undertook training with a university librarian and commenced the search iteratively, starting with some a priori terms, with the search developing iteratively, resulting in new search terms e.g. compassion satisfaction. These broader, related terms that often featured within the key concept literature, such as emotional intelligence, compassion satisfaction, compassion fatigue and emotional labour are also discussed. A structured approach was taken and the following questions were used to guide the literature review, with the review then being framed by dividing the literature into key themes and categories (Carnwell & Daly, 2001; Arksey & O'Malley, 2007):

- What is known about self-compassion in nursing?
- What is known about self-care in nursing?
- What is known about the relationship between how nurses care for themselves and compassionate care giving towards patients?

Table 2 presents an overview of search terms used; the full search strategy is presented in appendix 1. Boolean operators were applied to the search: AND was used to combine terms and searches and thus increase specificity; the truncation asterisk (*) was used to ensure similar words were found; a question mark (?) was used to ensure variations in spelling were located, for example traumatisisation and traumatization:

Table 2 – Search Terms

Search Terms	
<ul style="list-style-type: none"> - Compassion* - Self-compassion* - Self-care - Nurse wellbeing - Compassionate care - Nurse* - Nursing - History - Compassion Satisfaction 	<ul style="list-style-type: none"> - Compassion fatigue - Burnout - Secondary Traumatic Stress Disorder - Vicarious Traumatization - Emotional labour - Emotional intelligence

On commencing the review, I identified three key authors linked to compassion and self-compassion; Dalai Lama (Compassion & Self-compassion), Professor Paul Gilbert (Compassion), and Dr Kristen Neff (Self-compassion). I had prior experience of the work of these authors from my own clinical practice and my previous Masters by Research dissertation. I also was aware that their work is highly cited by others. Therefore, searches were made using these key authors in addition to the search terms outlined in Table 2.

III) – Data inclusion / exclusion

Studies were included if they were about self-care or self-compassion in nursing, or providing compassionate care. All literature directly related to these concepts was included. See table 3 for inclusion and exclusion criteria:

Table 3: Inclusion / Exclusion criteria

INCLUSION CRITERIA	EXCLUSION CRITERIA
About compassion; self-compassion; self-care and providing compassionate care in nursing. Other healthcare populations were also included (Patients, Doctors, Psychologists, Allied Health Professionals).	Literature published in other languages (unless translated)
English language	Literature unrelated to healthcare

No date restrictions applied	
All study designs, and opinion pieces.	

IV) – Date restrictions

No date restriction was placed on the initial search, due to wanting historical literature to ascertain whether the field of interest was represented in the early days of the nursing profession and whether it had changed over time. For stage 2, which took place once data collection and analysis had commenced, literature from 2014 onwards was searched for, to sensitise the concepts under study and to follow leads within the data.

2.3.2 – Selection of studies

This section describes the management of data extracted from the literature search and defines how studies were selected for inclusion within the review.

I) – Data Management

Endnote¹ was my bibliographical management software of choice. This enabled easy identification of duplications, organisation of references and the storage of articles.

II) – Selection of studies

Studies were selected for inclusion in the literature review based on their relevance to the area under study. References were screened and full texts of those appearing relevant were retrieved. The reference lists of retrieved texts were also searched for further articles of relevance.

The Critical Appraisal Skills Programme (CASP²) tools were used to guide critical appraisal of the research literature, by asking the questions: Are the results valid; what are the results and; will the results help? Following appraisal of the literature, a brief description and overview of each study was prepared in table format in Microsoft Word, focusing on the study aims, methodology, results

¹ <https://endnote.com>

² <http://www.casp-uk.net/casp-tools-checklists>

and an evaluation of the study. Examples can be viewed in Appendix 2. Items included in the data extraction can be viewed in table 4:

Table 4 – Information included for data extraction

<ul style="list-style-type: none"> - Title and abstract - Author(s) - Study aims - Methodology - Data analysis and management - Ethical approval / issues - Results and key findings 	<ul style="list-style-type: none"> - Transferability or generalizability - Key conclusions - Implications for future research - Usefulness and implications for practice - Limitations
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III) Synthesis of findings

Due to the varied nature of the literature reviewed, which included primary research, reviews and opinion pieces, a meta-analysis was not possible. Whilst this review was not a formal systematic review i.e. Cochrane³, an organised, logical, iterative and systematic approach was undertaken (Mays et al, 2001; Bettany-Saltukov, 2010). Sandelowski (2008) argues that the use of a rigid protocol in a literature review is not mandatory, although provision of a clear structure and audit trail may aid rigour and trustworthiness.

I therefore present a narrative discussion exploring ideas from the literature in relation to my field of interest. Greenhalgh et al (2018) state narrative reviews provide interpretation and critique with the aim being to provide a key contribution in deepening an understanding of the topic of interest. I focus on patterns and inconsistencies within the literature, in order to seek out and critically explore and explain commonalities and differences in the published data.

³ <http://www.cochranelibrary.com>

2.3.3 – Summary

This section has presented the methods employed to conduct the literature review. It has incorporated the search strategy, and how retrieved data were extracted, organised, managed and appraised. The following sections present and discuss the findings.

2.4 – Review findings

My review identified a number of key concepts emerging from the literature offering insights into the issues of how nurses care for themselves and how this may be linked to care giving. Some of these key concepts originated from my own starting ideas and assumptions (self-compassion, self-care and compassionate care), whilst others emerged through the process of the literature review (compassionate care delivery and its barriers, emotional intelligence, emotional labour, negative consequences of care giving and current wellbeing interventions for nursing staff, including resilience).

The results of the search strategy are reported in Table 5 with further detail being found in appendices 1 and 2:

Table 5 – Search results

Search	Results following filtering and the removal of duplicates
Compassion	22
Self-compassion	23
Self-care	12
Compassionate care (including: Education)	41
Broader associated terms (Combined with primary concepts):	
- Compassion satisfaction	15
- Compassion fatigue & Burnout	13
-Secondary Traumatic Stress & Vicarious Traumatization	18
-Emotional Labour	13
- Supervision	8
- Mindfulness	6
- Resilience	7
- Schwartz Rounds	3

Total	181
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The following key concepts relating to the research questions will be explored in more detail, and critically discussed to allow for an understanding of what is known from the literature and what is missing: compassion; self-compassion; self-care, and compassionate care.

2.4.1 – Compassion

The first concept I examined was that of compassion. My analysis revealed four subthemes, including definitions, the evolutionary basis of compassion, historical perspectives and religious ideals.

I) Defining compassion

The literature revealed a range of definitions of compassion, although consistency was shown through a focus on suffering and its alleviation (Dalai Lama, 2001). The etymology of the English word compassion is the Aramaic ‘racham’, from biblical times, meaning to love, pity and be merciful. The English version is derived from the Latin ‘com’, meaning ‘together with’, and ‘pati’ meaning ‘to suffer with’ (Reyes, 2012, p81; Burnell, 2009). Hence, within the literature the two key components of compassion appear to be the ability to engage with and acknowledge suffering, and commit to relieving it. In this respect, compassion could be seen as a behaviour or motivation (Paley, 2013), or as an emotion and *‘an altruistic virtue that involves concern for the good of the other person, an imaginative awareness of the other’s suffering, and a desire to act in order to relieve that suffering’* (Pask, 2005, p170-171). Gilbert (2010) brings the two together, writing that compassion involves a range of feelings, thoughts and behaviours. Table 6 highlights the key definitions within the literature:

Table 6: Compassion Definitions

Author	Definitions of Compassion
Dalai Lama (2001)	Focuses on sensitivity to suffering, encompassing the self and others. It also focuses on the need to commit to alleviating the suffering.
Gilbert (2010)	Defines compassion by exploring the components that aim to nurture the self and others with a focus on soothing, acceptance and belonging.

Despite consistent definitions from key authors, compassion as a concept appeared poorly defined and understood within the healthcare context. This was revealed by inconsistencies across a range of data sources, as noted in a systematic review, completed by Perez-Bret et al (2016), based on a total of twenty-eight articles. The authors concluded that compassion could be difficult to understand, yet appeared to be a duty in healthcare professional's daily work. Sinclair et al (2016a) agreed with this notion in their scoping review of the compassion literature, observing a limited understanding of compassion in healthcare and the need for a deeper insight into key behaviours and attitudes associated with it. Kneafsey et al (2015) in their qualitative exploration based on focus groups with 45 stakeholders, highlighted the importance of emotional connection and empathy.

Cultural and socio-political differences in how compassion is both defined and understood was noted in an international study of nurses' views and experiences of compassion completed by Papadopoulos et al (2016). They conducted a cross sectional descriptive study, using an online compassion questionnaire with 1323 nurses opting to participate from fifteen countries. The online questionnaire was devised by the lead author and consisted of open ended and closed questions drawn from the current literature within the field of compassion. They concluded that definitions varied by country. This affects the ability to measure compassion, linking to the research by Tierney et al (2016), which raised the importance of the manager embedding this in practice. Likewise, Papadopoulos et al (2016) suggested more understanding of the influence of workplace culture on compassion was required and for managers to offer staff compassion. They also mentioned the need for compassion to be embedded within nursing education.

There appears to be a key relationship with the role modelling of compassion by leaders and its subsequent practice. However, this study by Papadopoulos et al. (2016) had several limitations, including self-report bias and the unknown reliability and validity of the questionnaire.

How compassion is defined within the existing literature sensitised me further to the concept, alongside how it is perceived and experienced. The evolutionary basis of compassion and historical perspectives, incorporating religious ideals, also emerged as areas I wanted to consider.

II) Evolutionary basis of compassion

The literature highlighted the evolutionary basis of compassion. Gilbert (2010) postulated that compassion and care originates from our evolved abilities related to mammalian bonding, attachment, our affiliation system and other prosocial behaviours. He depicted our affiliative system as the ‘soothing’ system, identifying that our early experiences of care can influence its development. Over an extended period of time, through repeated exposure to experiences of care, he argued a neuronal connection could be formed in the brain within our soothing system, a view shared by other authors (Carter, 1998; Depue & Morrone-Strupinsky, 2005).

Gilbert (2006) identified the need for a compassion-focused approach within the psychological therapies. In a compassion-focused approach, the emphasis remains on the patient, whilst acknowledging the impact regarding self-compassion and self-care on the caregiver. This can then form the basis of an individual’s capacity for compassion towards the self and towards others (Bowlby, 1969; Gilbert, 2010). It suggests the importance of early childhood experiences related to being cared for but could encompass early nursing experiences such as role models or mentors and the key messages and experiences nurses encounter regarding whether they feel cared for within their workplace.

If individuals were to thrive and function within the world there was a need to be cared for, to be able to be self-caring and to belong within society. This was

depicted as a primary need, which must be in place before extended care giving can occur (Gilbert, 2010). Compassion can thus be viewed as an evolved process, from an early means of self-protection and protecting offspring, to then a broader focus towards protecting others and finally extending this to incorporate those outside the immediate kinship group (de Waal, 2009). This was an interesting point as nurses are expected to care for those outside their kinship group on a daily basis, suggesting the need for a highly evolved ability for compassion towards others.

The importance of compassion to self and others sits within the field of psychology and its clinical application, however this message could not be found within the nursing literature. This shows a possible tension and inconsistency between the health professions.

III) Historical perspectives and religious ideals

When searching the literature, a small amount of evidence on compassion in healthcare from a historical perspective was found. This is helpful in considering how far compassion is embedded within nursing culture. It can be seen from historical papers where a focus on putting the patient first has arisen within nursing, as it progressed from its historical roots in religious orders to becoming a profession. For example, Florence Nightingale warned her nurses to let compassion be a motivating factor to care, without letting their emotional responses to suffering overwhelm them (Nightingale, 1898). She appeared to show an awareness of a nurse's own emotional welfare, but placed a focus on caring for the patient in the first instance; managing or disconnecting from one's own emotions was therefore called for when necessary. So, historically, there was a pressure to be fully committed to the patient (Nightingale, 1898; Houghton, 1938), with the act of care-giving focusing on the need for the qualities required to be a nurse, without emotions interfering in this. Nightingale's ideas around self-awareness and emotional management were reinforced by Hector (1960), who noted that nurses required mental and physical strength to complete their work, indicating a need for emotional resilience.

Sections of the reviewed literature focused on a religious element to the art of compassion being practiced; engaging in compassionate deeds or actions with those in need or the sick was perceived to be an act of striving to become god-like and considered to be a pre-requisite to salvation (Kapelli, 2008). Ideas around religion and faith are held within the history and roots of nursing (Sellman, 1997), and a compassionate religious ideal appears to have been perpetuated for decades (Dossey, 2007). However, it remains unclear within the literature whether present day nurses experience or view compassion in this way, and it is important to note that not all nurses align themselves with ideas relating to faith and nursing. As society developed, the responsibility for caring for the sick moved from the control of religious orders into the realm of professional nursing; nurses were left to navigate and meet the challenge of attending to these historical, theological ideals, whilst moving towards professionalism (Bingham, 1979).

Nightingale paved the way for professional nursing and it is useful to note her apparent focus on emotional welfare. However, other viewpoints were expressed within the literature. For example, Wood (1878) advocated that nurses must think only of their patient's comforts and place all focus on them, not on themselves. Landale (1893) supported this idea of compassion outwards rather than inwards by taking the view of service coming before self as the only motivation suitable for nurses. Bradshaw (2011) concluded in her narrative piece on historical features of compassion that *'compassion is not strained by pressure or displaced by stress. The greater the hardship, the more compassion is required. Genuine Compassionate Care is not a quantifiable skill, an assumed technique or an emotion or feeling. It is the humane quality of kindness'* (p14).

As outlined above, views on compassion within nursing have changed over time, with clear differences between Nightingale's descriptions and more modern interpretations and ideals. The literature was unable to provide solid examples of how nurses cared for themselves in the past and appeared to favour the ability to distance oneself from the more difficult emotions that arise from nursing.

IV) Summary

Compassion as a term within the literature appeared to hold many consistent definitions, which mostly included an awareness of the suffering of others, a wish to alleviate this, and action taken with this aim. Nurses were expected to heal the sick and respond to their ‘calling’ but how nurses care for others if their own physical or mental wellbeing was compromised was not addressed. Within the historical context there were hints of recognition regarding the importance of emotional wellbeing, resilience, self-compassion and self-care. However, there was an apparent dearth of literature of more substantive examples of how nurses cared for themselves in past times. The focus appeared to be placed on compassion towards another, with a full commitment towards the patient.

What the literature does suggest from an evolutionary standpoint is that as human beings we have an inbuilt need to be and feel cared for, which if fulfilled allows us to extend our caring outwards. It is interesting to think about the expectation referred to in the historical literature of nurses putting patients first and caring for others. Yet nurses are human beings with needs, which can be neglected at the expense of caring for the self, as will later be explored. Mills et al (2014) suggested that the literature to date has focused on compassion deficits across nursing, adding that some consideration be given to both self-care and self-compassion within this professional group. How compassion is applied to the self will now be explored.

2.4.2 - Self-Compassion

The second concept I examined was that of self-compassion. My analysis revealed seven subthemes, including definitions, how it relates to wellbeing, how it relates to emotional intelligence, quality of life and burnout, how it relates to compassionate care, and the self-compassion research conducted with both clinical and student populations.

I) Defining Self-Compassion

Self-compassion was defined within the literature as the ability to be compassionate towards oneself (Heffernan et al, 2010), to turn kindness inwards and to honour and acknowledge our humanity, our imperfection and our fragility

(Lindstrom, 2014). A large proportion of the existing evidence related to self-compassion was conducted by Dr Kristen Neff, who defines self-compassion as *‘Being open to and moved by one’s own suffering, being caring and kind towards the self, understanding and having a non-judgemental attitude towards the inadequacies and failures and recognising one’s experience as part of human experience’* (Neff, 2003, p224). Neff (2003) situated self-compassion within the Buddhist tradition, arguing that an individual cannot be compassionate for another unless possessing self-compassion. Likewise, the Dalai Lama (2003) identified *‘for someone to develop genuine compassion towards others, first he or she must have a basis upon which to cultivate compassion, and that basis is the ability to connect to one’s own feelings and to care for one’s own welfare... caring for others requires caring for oneself’* (p125). Whilst not directly writing for nurses or other healthcare practitioners, this supports the idea that in order to care for others some consideration of one’s own needs is important.

Several components to self-compassion were identified within the existing literature: Self-kindness (Neff, 2003), common humanity, mindfulness, and wisdom (Leary et al, 2007; Neff et al, 2007; Neff & Vonk, 2009; Shepard & Cardon, 2009 & Thompson & Waltz, 2008). Self-kindness frequently sat within self-compassion, suggesting it may be one of the main components of this term. Table 7 provides the key definitions of self-compassion found within the literature:

Table 7: Self-Compassion Definitions

Author	Definitions of Self-Compassion
Neff (2003)	Openness and being moved by one’s own suffering, recognition of humanity and being kind to the self. Suffering is recognised as part of the human condition and therefore a universal experience.
Heffernan et al (2010)	Ability to be compassionate towards the self.
Lindstrom (2014)	To be kind to the self, acknowledge humanity and fragility.

The literature also noted times when self-compassion may be required, with Neff (2009) proposing *'compassion can be extended towards the self when suffering occurs through no fault of one's own when the external circumstances of life are simply painful or difficult to bear. Self-compassion is equally relevant, however, when suffering stems from one's own foolish actions, failures or personal inadequacies'* (p212). This conveyed the importance of self-awareness to recognise a time when self-compassion is needed. Much of Neff's work focused on student and clinical populations; however, many of the ideas and themes could be transferable to healthcare professionals. From this perspective it is interesting to think about how self-awareness and recognition of the need for self-compassion are experienced within the field of nursing.

There was a dearth of literature specifically focusing on how self-compassion is defined in nursing. Reyes (2012), in her concept analysis of self-compassion, covering literature from 1979 to 2010, found only 1 out of 74 papers looking at self-compassion that focused on nursing (Heffernan et al, 2010), which focused on the relationship between self-compassion and emotional intelligence (later explored). The discipline areas that did explore self-compassion were psychology, religion, philosophy, sociology and management. Her conclusion to this paper was that *'to be useful for nursing, self-compassion must meet the following criteria: a) what patient need does self-compassion meet? b) How would self-compassion guide nursing actions? c) How does the concept of self-compassion enhance clinical outcomes?'* (p87). This presents a utilitarian picture of self-compassion and appeared entirely patient focused rather than taking account of the nursing perspective and experience, and the dual process of compassion inwards and outwards proposed by the Dalai Lama (2003). It sits with the notion of patient first and the ideas presented within the Nursing Code (NMC, 2015), which lacks a focus on care and compassion towards the nurse; the only point in the code (20.9) referring to a nurse's own wellbeing states the requirement to *'maintain the level of health you need to carry out your professional role'* (p16).

Whilst the definitions above provide useful insights into self-compassion, there is a lack of literature on how self-compassion is experienced and viewed, beyond

the notion of being kind to oneself. Therefore there appears a need to gain an understanding, from nurses themselves, whether and how it is experienced.

II) Self-compassion and wellbeing

Whilst searching the literature, self-compassion was often situated with wellbeing (Barnard & Curry, 2011; Reyes, 2012; Zessin et al, 2015). This is interesting to consider from a nursing perspective due to nursing guidance making little reference to the importance of a nurse's wellbeing. Zessin et al's (2015) review, looking at the relationship between self-compassion and wellbeing, identified 79 usable articles. They found there was a strong relationship between self-compassion and psychological wellbeing, suggesting that self-compassion improved psychological wellbeing. A number of limitations were noted, including a lack of experimental research and the heterogeneous nature of the definitions of wellbeing. Barnard and Curry's (2011) review focused on conceptualisations, correlates and interventions of self-compassion. They suggested that those who engage in self-compassion are less likely to have mental health difficulties and are more likely to experience better life satisfaction, develop and hold more effective coping strategies and possess higher levels of emotional intelligence. This apparent positive impact on mental health will be further explored with the patient literature later in this section. However, it should be noted that their review methodology was unclear, with no cited inclusion or exclusion criteria.

III) Self-compassion and nursing

As nurses are the focus of this thesis, it was essential to explore the current evidence base related to self-compassion in nursing. Five published studies were located investigating this topic; four were questionnaire based, providing quantitative data (Heffernan et al, 2010; Senyuva et al, 2013; Duarte et al, 2016; Durkin et al, 2016), and one was qualitative (Gustin & Wagner, 2013). Two of them demonstrated a positive relationship with emotional intelligence (Heffernan et al, 2010; Senyuva et al, 2013), two noted that self-compassion positively influences quality of life and the management of emotions (Duarte et al, 2016; Durkin et al, 2016) and the final study focused on a clinical educator's

understanding of self-compassion as a source for compassionate care (Gustin & Wagner). These findings will now be further explored.

a) Emotional intelligence

Emotional intelligence appears to hold a key relationship with self-compassion; in order to access self-compassion an individual needs to be emotionally aware and able to identify emotions to be processed and managed. If emotional intelligence links to self-compassion in this way, and is a possible precursor to a nurse being able to be compassionate towards themselves, then this has implications for future research ideas and how to increase and cultivate self-compassion in healthcare. Of the four quantitative studies found when looking at self-compassion and nursing, two demonstrated a positive relationship between self-compassion and emotional intelligence (Heffernan et al, 2010; Senyuva et al, 2013).

The link between emotional intelligence and self-compassion was suggested by Neff (2009), who stated '*self-compassion is strongly associated with emotional intelligence and wisdom...self-compassion involves the desire for the self's health and wellbeing, and is associated with greater personal initiative to make needed changes in one's life*' (p213). Emotional Intelligence was defined by Salovey and Mayer (1990, P189) as '*the ability to monitor one's own and others' feelings and emotions, to discriminate among them and to use this information to guide one's thinking and actions*'. This links self-compassion with an emotional awareness and an ability to manage emotions. Emotional intelligence can be viewed as a set of traits and abilities (Bar-On, 2005) and a combination of skills and personal competencies (Goleman, 1998). Freshwater and Stickley (2004) argued for emotional intelligence competencies to be made explicit within nursing education, with the literature acknowledging emotional experiences and the emotional reality of nursing practice (Bellack, 1999; MacCulloch, 1999).

The relationship between emotional intelligence and self-compassion was explored by Heffernan et al (2010), in their study with American nurses (n=135). They were unable to identify any previous studies on nurses and self-compassion. Their results showed a positive correlation between self-compassion and

emotional intelligence. However, although they found that participants possessed high levels of self-compassion they still concluded that additional ways to improve self-compassion were required. A major limitation of the study was its use of the Self-Compassion Scale (Neff, 2003), which has been criticised for its scoring and validity. Neff has noted that the scale should be analysed as a unitary measure, whereas many researchers continue to score and analyse using a binary method (Lopez et al, 2015).

Senyuva et al, (2013) also had problems with measurement tools; in their correlational study an emotional intelligence questionnaire was used that had been constructed for management and executive populations. Their sample consisted of undergraduate nursing students (n=471) from one educational facility, who had little clinical experience, making it difficult to generalise findings to a nursing population. Senyuva et al (2013) highlighted the positive correlation between emotional intelligence and self-compassion, and pointed out that participants had low levels of emotional intelligence and self-compassion, with this likely leading to problems in understanding the emotions of a patient and their family.

Emotional intelligence may be viewed as a means of managing emotions in nursing. Donoso et al (2015) studied the positive impact of emotional demands at work, finding that if nurses manage their own emotions there is a positive correlation with motivation at work and an overall sense of wellbeing. Many nurses are placed in situations whereby they need to go from one patient to the next, whilst holding a number of often competing emotions. Emotional intelligence may be a means of managing this process. Rogers (1980), a psychologist, wrote *'before I go into any room I remind myself that I am not perfect. I am human. Therefore, I am capable of any thought / emotion / act that has ever been had'* (p43). This places the focus on accepting one's limitations and resonates with self-compassion, acknowledging mistakes and adapting in order to learn and move forward.

The ideas presented within the literature relating to emotional intelligence and managing one's emotions appear important. However, the literature also presented ideas of how self-compassion may relate to quality of life and burnout.

b) Quality of life and burnout

The literature review identified two studies focused on self-compassion and its relationship to quality of life and the risk of burnout in nursing. Durkin et al (2016), in their cross sectional study with UK nurses in the community (n=37), found that if community nurses were more self-compassionate, they were less likely to suffer from burnout. They concluded that building self-compassion and resilience may have benefits in terms of reducing compassion fatigue and burnout. A Portuguese study by Duarte et al (2016) involved a larger sample (n=280) and produced similar findings, noting that self-compassionate people are more able to regulate their emotions. This is an interesting direction as emotional intelligence is posited as required in order to be self-compassionate and if an individual is self-compassionate they are more able to regulate emotions. They reported a positive relationship between self-compassion and professional quality of life, with increased quality of life reducing the risk of burnout. They concluded that *'teaching self-compassion and self-care skills, i.e. a tendency to be kind and understanding toward oneself, to feel interconnected with other people and to hold negative experiences with mindful awareness, may be an important feature in nursing educational interventions that aim to reduce burnout and compassion fatigue'* (p9).

There is limited research looking at self-compassion and its impact on quality of life and burnout in nursing, so it is an important area for further exploration. If nurses are to experience a good quality of life and reduce the risk of burnout then an understanding of the need for self-compassion may be important. By exploring a nurse's experience of self-compassion, whether it has a place in how nurses care for themselves can be explored.

c) How it relates to compassionate care

Compassionate care is fully discussed later in the chapter, however whilst exploring the concept of self-compassion within nursing, the following study

seemed important. Gustin and Wagner's (2013) qualitative study used a hermeneutical method to understand self-compassion as a source to compassionate care. It comprised a very small sample size (n=4) and, although this is in keeping with a phenomenological design, the method followed was not clear, nor was it stated that the research had undergone an ethical review. These authors did report that self-compassion is about acknowledging human mutuality and confronting one's own as well as a patient's vulnerability in a caring situation. Their findings revealed that the development of a compassionate self and the ability to be sensitive, non-judgmental and respectful towards oneself contributed to a compassionate stance towards patients. This links to the definitions of self-compassion, reinforcing the ideas suggested by Neff (2003), but extends the line of thinking in regard to compassionate care giving and the impact of self-compassion on the stance taken towards a patient. Nurses might therefore need to appreciate that in order to take a compassionate stance towards another, a compassionate stance towards the self might also be necessary.

Due to the small number of studies exploring self-compassion in nursing and its possible important links to emotional intelligence, quality of life, burnout and relationship to compassionate care, it was felt necessary to explore the wider literature encompassing other populations.

IV) Self-compassion and clinical populations

Several studies looked at the cultivation of self-compassion in a mental health patient population (Gilbert & Irons, 2004; Neff et al, 2005; Shapiro et al, 2005; Gilbert & Proctor, 2006; Neff et al, 2007; Mayhew & Gilbert, 2008; Neff et al, 2008; Neff & Vonk, 2009; Harman & Lee, 2010; Pauley & McPherson, 2010). These studies showed positive findings that self-compassion could be achieved and improved upon if it was better understood and practiced, resulting in a positive impact on mental health and wellbeing. Hence, there is evidence from the patient literature to support the claim that self-compassion can be nurtured. This was often achieved through education, therapeutic intervention and practice. Many studies discussed the need to cultivate self-compassion over a long period of time, with it being taught by someone trained in compassion focused approaches. This suggests that as a concept it may not be readily accessible but

rather takes some work to cultivate and nurture, which could be a consideration when extended to nursing education and practice.

V) Self-compassion and student populations

Another tranche of research centred on the impact of self-compassion within student populations (Neff, 2003; Gilbert et al, 2004; Gilbert et al, 2006; Leary et al, 2007; Neff & McGehee, 2010; Zabelina & Robinson, 2010; Beaumont et al 2016; Campion & Glover, 2016). These studies showed positive correlations between self-compassion and emotional wellbeing, resonating with the literature review conducted by Zessin et al (2015). Leary et al (2007) proposed that if self-compassion increased, this would mean better overall wellbeing and the moderation of reactions during distressing situations; their research supported this hypothesis. However, it comprised five separate studies focused on a population of undergraduate psychology students (n=523), whom it could be argued were likely to already have an understanding of the role and meaning of self-compassion as part of their psychology teaching.

Self-judgement as part of self-compassion was also noted within the literature, in a study completed with student midwives (n=103) by Beaumont et al (2016). Results showed that if they scored highly on self-judgement, this was linked to lower levels of self-compassion, lower levels of compassion for others, lower levels of wellbeing, increased burnout and compassion fatigue. It was therefore concluded that midwives may benefit from being kinder to themselves when faced with suffering and from the cultivation of environments fostering self-compassion. However, data were gathered at a single time point and from one institution. Nevertheless, results highlight the importance of self-judgement as part of self-compassion.

The above patient and student literature resonated with the nursing literature previously mentioned; with findings supporting the claim that self-compassion reduces the risk of burnout and increases emotional wellbeing. Yet evidence was found that self-compassion may be perceived as both positive and negative, presenting a possible barrier as to why it is not embedded within nursing culture. Campion and Glover (2016) qualitatively explored the meaning of self-

compassion in a sample of postgraduate students and staff at a university (n=12). Three themes were identified; benefits of self-compassion, being self-compassionate and barriers to self-compassion. They concluded that participants thought that being self-compassionate would be beneficial, but also believed it may make them vulnerable and that others would judge them for prioritising themselves, unless another had role-modelled self-compassion in the first instance. Participants acknowledged the need for a cultural change for self-compassion to be acceptable. This resonates with the idea of patients coming first, again sitting with guidance provided in 'The Code' for Nursing and Midwifery (NMC, 2015). Thus, there appears to be a need to embed self-compassion within society for individuals to feel empowered to use it; self-compassion could be hard to accept in a healthcare sphere if it is not accepted within the wider culture.

VI) - Summary

Self-compassion is clearly defined within the literature and relates to how we treat ourselves as human beings. It acknowledges the need for self-kindness, recognising our own humanity and using wisdom and emotional intelligence. It suggested that self-compassion is necessary in the first instance before compassion can be extended outwards and offered to others. It showed that self-compassion positively impacts upon wellbeing and mental health, but many of the studies focused on patient and student populations rather than healthcare staff. The literature has been unable to inform how self-compassion is experienced by nurses, suggesting a gap in the knowledge base.

A small number of studies have explored self-compassion in nursing. These were mostly quantitative in their design, making it difficult to explore meaning and how nurses experience it as a concept. These studies highlighted the importance of cultivating self-compassion, particularly to help prevent more negative effects of caring. Literature situated within other populations concurs with the need to cultivate compassion, due to its perceived benefits. However, there was also evidence that self-compassion may lead to people feeling vulnerable and judged for prioritising the self. Whether this extends to nurses is not clear.

Within the self-compassion literature, emotional intelligence featured, suggesting a possible link. It could be hypothesised that emotional intelligence allows one to recognise the need for self-compassion. Research that focuses on emotional intelligence notes its importance in healthcare due to the range of emotions often experienced by staff. There is a suggestion that having increased emotional intelligence can contribute to better performance and motivation at work. Self-compassion within the literature was linked to wellbeing and positive mental health, indicating a possible link to self-care, a concept that will be explored next.

2.4.3 - Self-care

The third concept I examined was that of self-care. My analysis revealed five subthemes including definitions, self-care as a buffer against the negative impact of nursing, promoting self-care in patients, current wellbeing initiatives for nurses and healthcare staff, and the need for resilient practitioners.

I) Defining Self-Care

Self-care within the literature was defined as the steps individuals take to establish and maintain health (WHO, 1983; DoH, 2005), or to prevent disease or illness (Webber et al, 2013), and activities people engage in with the purpose of managing their physical and emotional health (Lee & Miller, 2013). It appears to differ from self-compassion, which focuses on awareness of the self and treating oneself with kindness, whereas self-care is around self-management and prevention of ill health. Hence, although complementary they appear to be separate constructs.

Wilkinson and Whitehead (2009) noted an element of confusion between the terms self-care and self-management, with both used interchangeably within the literature. This confusion was supported by Richard and Shea (2011), who did however state that self-care was the more commonly used term of the two. They proposed that self-management encompasses the need to take responsibility for one's own wellbeing and behaviour, concluding that it could be viewed as similar to or alongside self-care. Self-management as a term within the literature often

referred to models of coping, self-help, self-reliance and seeking the support of others when managing long term conditions (Thorne et al, 2003; Newbould et al, 2006). In contrast, Roberts (1999) proposed self-care as a broad concept, and related it to societal interests in autonomy, self-direction and personal responsibility. Likewise, Gantz (1990) described self-care as a movement, a concept, a framework, a model, theory or phenomenon, suggesting that it is far bigger than just attending to needs, but rather encompasses a focus on the wider culture and environment. This paper placed a focus on ‘individual control’, reinforcing the self and importance of individual ownership.

As the above descriptions show, and as outlined in table 8, there is a lack of consistent definition when it comes to self-care, although it seems to focus on preventing ill health. This supports a need for my study, to clarify its meaning in relation to nursing:

Table 8: Definitions of Self-Care

Author	Definitions of Self-Care
WHO (1983); DoH (2005)	The steps an individual may take in order to establish and maintain health.
Webber et al (2013)	The prevention of disease or illness.
Lee and Miller (2013)	Engaging in activities with the purpose of managing both physical and emotional health.

II) Self-care as a buffer against traumatisation

It appears the research to date on self-care among health professionals has focused on buffering against the negative effects of working with traumatised individuals (Maslach, 2003; Sabin-Farrell & Turpin, 2003; Dominguez-Gomez, 2009; Newall & MacNeil, 2010; Elwood et al, 2011; Salloum et al, 2015). Whilst most of these studies showed a need for increased training, supervision and self-awareness, they all recommended that further research within this field was required. Mills et al (2014) added, in a guest editorial rather than a research-based paper, that if decisive action is not taken and attention paid to self-care, the trend of this being undervalued for healthcare professionals would remain. They advised that nurses are unlikely to practice self-care if they are not explicitly

trained to do so. Teaching self-care did not feature within the literature, but rather a focus on nurses promoting self-care for their patients and current initiatives in the management of emotions.

III) Self-care promotion in patients

Much of the self-care literature focuses on how to support and encourage patients to attend to their own condition (Webber et al, 2013; Richards, 2013; Davidhizar, 1993); there was a lack of literature focused on nurses' or caregivers' ability to self-care, or the meaning of self-care to them in their professional role. Richards (2013) did refer to a dual process, purporting that self-care is vital and will benefit both nurses and their patients, with the expectation that self-care is encompassed within the professional role of the nurse. This emphasis on personal responsibility aligns with nursing guidance as outlined in 'The Code' (NMC, 2015).

Orem's (1981) self-care model featured heavily in the self-care literature, with a focus on facilitating and empowering patients to attend to their own self-care needs. In line with other self-care definitions, Orem (1985) defined self-care as the practice of activities that individuals initiate and perform on their own behalf in maintaining life, health and wellbeing. The model is often applied in practice and education (Hutchinson, 1987). Whilst patient focused, the model has been found to have flexibility and adaptability and offers a potential framework for nurses (Davidhizar, 1993). As the model presents a framework to bring about behavioural change, this could enable nurses to take a structured view of their own needs and the barriers to these. However, as with the nurse empowering the patient to take control of their self-care, there is a need for the nurse themselves to take control of their own needs or be enabled by another.

IV) Current wellbeing initiatives for nurses and other healthcare disciplines

Organisations are starting to acknowledge the importance of caring for their workforce (Rose and Glass, 2006) and a number of initiatives are being used to enable nurses to manage their wellbeing. In line with Orem's ideas around the promotion of self-care for patients, self-care appeared in the wider healthcare

literature in terms of organisational initiatives for the healthcare workforce. Neville and Cole (2013) identified support for engagement in health promotional behaviours as having the potential to contribute to and enhance a nurse's wellbeing, counteracting some of the negative effects of nursing, such as compassion fatigue and burnout whilst enhancing compassion satisfaction (these terms are discussed later in the chapter).

Supervision has been proposed as a key way of managing emotion in healthcare (Lyth, 2000; Buus et al, 2013) and as a means of reducing burnout (Edwards et al, 2005; White & Winstanley, 2010; Koivu et al, 2012). Supervision is recognised for its benefits regarding skill development, risk management and improved patient outcomes (Butterworth et al, 2008), and is said to uphold the emotional energies required to care (Proctor, 2010). MacLaren et al (2016) completed a narrative inquiry study with eight mental health nurses, resulting in three feelings associated with supervision: safety and reflexivity, staying professional and managing feelings. They also noted two feelings associated with the organisation, which contrasted with those associated with supervision: being stoical (feeling pain and distress without showing it) and inferiority (feeling lower in status). They reinforced the need for engagement in the process of supervision, even if experienced emotions conflicted with the rules of the organisation, in order to try and develop an effective emotional culture.

Another way in which organisations have tried to address staff's wellbeing is through the use of Schwartz rounds (George, 2016). They were developed in America as a way of bringing in trained facilitators to enable staff to reflect upon thoughts and feelings related to their job in a safe environment during protected time. Those engaged in this process have reported that being with others who felt the same way was helpful and caused them to normalise the stress experienced (George, 2010). Goodrich (2016), when reviewing the impact of Schwartz rounds, found there was much discussion surrounding compassion fatigue and the use of strategies to protect oneself both physically and emotionally. This resonates with research conducted by Menzies Lyth (1960), described in more detail below, when discussing emotional labour, which focused on unconscious defence mechanisms and staff distancing themselves to cope.

Mindfulness featured within the literature as another action that could help with staff wellbeing. Grossman et al (2004) defined mindfulness as a moment-to-moment awareness of perceptible mental states and processes; it includes an immediate and continuous awareness of any physical sensations, perceptions, affective states, thoughts and imagery being experienced. A major aim of mindfulness practice is the cultivation of a more accurate view of how the mind is operating, and to raise an awareness of the present moment (Kabat-Zinn, 1982). The roots of mindfulness are based in Buddhism. However, Jon Kabat-Zinn (1982) introduced Mindfulness Based Training (MBT) and Mindfulness Based Stress Reduction (MBSR), which are more secular. A review of the literature completed by Hofmann et al (2010) suggested that mindfulness is a beneficial intervention, which can reduce negative psychological states such as stress, anxiety and depression. Most literature on mindfulness focused on patient populations, but a small number of studies have looked at the use of mindfulness within nursing. Pipe et al (2009), in their randomized controlled trial with a nurse leader population (n=33), found that a MBSR course for nurse leaders showed a reduction in stress and anxiety whilst improving self-awareness and nurturing skills. They noted that nurse leaders who possess self-awareness and participate in self-reflection are more effective in caring for their staff team and are supportive of stress management and reduction techniques. The study used self-report measures at two time points - commencement of the course and one week post course completion. The sample size was fairly small given that participants were randomised into the mindfulness or a control group completing non-mindfulness based leadership programme. Pipe et al's (2009) work was supported by Cunningham and colleagues (2013) in their investigation of mindfulness approaches to improve work life balance and nursing retention, although this study was presented more as a narrative and reflective piece with no clear methodology or rigour.

Although the literature proposes a number of interventions and initiatives that may benefit nurses or other healthcare professionals' wellbeing, there is a need for availability, and accessibility of these interventions and for it to be embedded within practice. The aim of these initiatives appeared to be about enabling the process of reflection and the management of emotions; it could be argued that

these are used as a means to build resilience.

V) Resilient practitioners

In order for clinicians to care for themselves, the ability to become resilient practitioners is noted within the literature. Resilience has been described as an ability to rebound from or adapt to adverse situations (Marsh, 1996; Newman, 2003). There was some literature on developing resilience to prevent burnout (Skovholt & Trotter Mathison, 2011), with self-care strategies proposed for counsellors, therapists, teachers and health professionals. These strategies revolve around self-assessment, self-awareness and reflection. It was proposed that if these abilities are nurtured then a more resilient practitioner is created (Skovholt & Trotter Mathison, 2011). McAllister and McKinnon (2009) noted that individuals and groups that are able to display resiliency have a tendency to possess a set of common characteristics that equip them with useful coping strategies. These characteristics - internal locus of control, pro-social behavior, empathy, positive self-image, optimism and the ability to organize (McAllister & McKinnon, 2009) – are said to enable positive, supportive relationships with others and to make people more adaptable to change (Friborg et al, 2003).

Nurses may need to foster self-care abilities to remain resilient in the face of challenges experienced in their daily work life (Delgado et al, 2017). For example, Jackson et al (2007) in their review of the literature found that resilience is a necessary quality to succeed in nursing. They argued that resilience should be taught within healthcare settings. They also described the need for self-care, acknowledging that although many nurses neglect their own wellbeing, it is important for developing resilience. McAllister and McKinnon (2009) emphasised the importance of positive facilitators and role models in this respect. Likewise, in a review of studies exploring nurses' resilience, Delgado et al. (2017) concluded that supportive workplaces and the recognition by organisations of the wellbeing of their healthcare staff was necessary.

VI) Self-care and other disciplines

Due to a lack of studies on self-care located within the field of nursing, literature from other disciplines was searched, including health psychology, allied health professions and education. Little was located focusing specifically on self-care apart from one study by Zahniser et al (2017), who explored self-care in clinical psychology graduate training with a sample of American students (n=358). Their quantitative findings showed that self-care is associated with both greater personal wellbeing and better self-reported progress. Findings placed importance on building professional support systems and self-awareness of one's own needs, concluding that if self-care is embedded within psychology training then individuals are more likely to engage. However, the rationale for choice of measures was unclear, and the sample was mainly PhD psychology graduates, therefore bringing generalisability into question.

VII) Summary

The literature on self-care at present appears limited, with few studies available in relation to nurses. Conversely, there were many narratives and commentaries, which whilst interesting in terms of expressed ideas do not specifically add to the research base. Hence, a need for more research around self-care in nursing.

The lack of studies is interesting, given the proposed benefits of cultivating self-care. This leads to the question of how self-care is experienced and viewed within nursing and healthcare, and whether it is considered to be of importance or not. Self-care as a term was defined within the literature, but it was unclear how this was experienced within healthcare. Much of the literature focused on patient populations. While research suggests both self-care and self-compassion may have a positive impact within nursing, a lack of evidence of how this may be achieved was noticeable within the current literature. Nevertheless, there is some indication of a move towards interventions to help nurses and other healthcare staff, manage their wellbeing. The current study aims to add to the evidence base by exploring the importance of self-care to more effectively manage emotions and prevent some of the negative effects of nursing practice.

Both self-compassion and self-care appear important when we consider the wellbeing of nurses, with self-compassion focusing on how we treat ourselves, such as offering ourselves kindness, recognising our wisdom and being aware of our own humanity and fragility. Self-care, whilst still being concerned with how we look after ourselves, places more of a focus on actions we take to prevent ourselves from becoming physically and/or psychologically unwell. The literature hints at a link between these two concepts and the ability to deliver compassionate care. This link between self-care and self-compassion and how it relates to delivering compassionate care will now be explored.

2.4.4 Compassionate Care

Literature reviewed revealed a number of themes related to the concept of compassionate care, incorporating its current context, how it is defined, how it is delivered, the barriers that prevent its delivery, student and newly qualified nurses being ill prepared for the realities of practice, and the tension between individual and organisational perspectives.

I) Current Context

Compassionate care is a key feature in nursing; it runs through nursing history (Bradshaw, 2011) into modern day nursing practice (Nursing & Midwifery Council, NMC, 2015). Within the NHS Constitution (DoH, 2009; 2015⁴), compassionate care is defined as *'we respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for those we serve and work alongside. We do not wait to be asked, because we care'* (p27). This reflects the aforementioned definitions of compassion, in the sense of being aware of and responsive to suffering. Some of these elements are also echoed within the Nursing Code (NMC, 2015): *'1.1. Treat people with kindness, respect and compassion, 1.2. Make sure you deliver the fundamentals of care effectively'* (p4). However, these points are broad and do not cover how delivering

⁴ <https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england>

compassionate care is achieved; recent reports suggest compassionate care is not always delivered (Francis report, 2013; Confidential Inquiry into the premature deaths of people with learning disabilities, CIPOLD, DoH, 2013).

The Department of Health (DoH) and NHS Commissioning Board (2012), in its ‘Compassion in Practice’ strategy, states *‘As health and social care changes what does not alter is the fundamental human need to be looked after with care, dignity, respect and compassion’* (p5). This strategy focuses on six fundamental core values; care, compassion, competence, communication, courage and commitment. It outlines a three year vision *‘to deliver high quality, compassionate care, and to achieve excellent health and wellbeing outcomes’* (p7), defining the term ‘compassion’ as *‘how care is given through relationships based on empathy, respect and dignity – it can also be described as intelligent kindness, and is central to how people perceive their care’* (p13). It highlights again how, within nursing, the focus is on compassion towards patients, without considering the need for compassion towards nurses themselves.

II) Defining compassionate care

Numerous definitions appeared whilst searching the current literature, as outlined in Table 9:

Table 9: Definitions of compassionate care

Author	Definitions of compassionate care
Fox (1990)	Compassionate care is about collaboration and seeking to avoid a paternalistic approach; to have a successful, compassionately caring approach a sense of togetherness must be formed.
Nussbaum (1996)	Links the definition of compassionate care with social justice, identifying that compassion is about what we choose to do together with others rather than choosing for them, with the caveat that compassionate care does not require us to fully immerse ourselves in others suffering purely to suffer too.

Von Dietze and Orb (2000)	Compassionate care is not simply taking away the pain and suffering of another, but rather entering that person's experience, sharing the burden and enabling them to retain their independence and dignity.
Frank (2004)	Giving and receiving compassionate care calls for an emotional response, going beyond the act of basic care, instead involving generosity, giving more than you may have access to, kindness and a very open and real dialogue.
Cozens and Cornwell (2009)	Identified the emotional side of compassionate care as often felt by both the carer and the patient.
Dewar et al (2014)	Identify compassionate care as an interpersonal and relational process that enables staff to gain energy and satisfaction

The above definitions place a focus on collaboration and entering into the experience of the patient in order to provide compassionate care. There seems to be some question as to how far a nurse/clinician does this, with debate about how emotions are experienced by both the clinician and patient. This highlights the link between caring for the self and caring for another. There are some contradictions between Nussbaum (1996) and Von Dietz and Orb (2000) in terms of how far suffering of the patient is entered into. Koerner (2004) noted that nurses hold a privileged position, witnessing and caring for individuals experiencing a health crisis. An opposing viewpoint would be that nursing exposes an individual to death, disease and suffering, calling for balance when entering the patient journey, with the need to offer compassion and care for the self as well as for patients.

Dewar et al (2014, p1744-1745) in their discussion paper, which drew on empirical findings, set out to clarify misconceptions about compassionate care, and noted the following implications for practice:

- *Identify and articulate compassionate care practice in healthcare settings, including 'the small acts that matter'.*
- *Celebrate and value compassionate care practices.*

- *Create working environments where relational approaches to care are encouraged.*
- *Work with patients to check out what matters to them as individuals and use this information to influence care giving.*
- *Incorporate caring conversations into daily work.*
- *Organisational support to enable staff to experience fulfilment in giving compassionate care.*
- *Support staff to engage in the practice of self-compassion.*

The above outlines a responsibility by individuals, teams and organisations to focus on compassionate care, but also highlights that if nurses are to deliver compassionate care then self-compassion forms a part of this.

III) Communicating compassion

Nurses can find it difficult to identify aspects of care-giving that communicate compassion (Sinclair et al., 2016a; Von Dietze and Orb, 2000). This could be problematic because Bramley and Matiti (2014) noted that if compassion is perceived to be absent then patients feel devalued and lacking in emotional support in their time of need. These authors completed a qualitative study with 10 patients to look at how they experienced compassion and their perceptions of developing compassionate nurses. They recruited a varied sample, with patients who had been in hospital for between 4 days to 8 weeks. This may have had an impact upon exposure to compassionate and uncompassionate actions. Their analysis resulted in three themes; 1) what is compassion: knowing me and giving me your time, 2) understanding the impact of compassion: how it feels in my shoes, and 3) being more compassionate: communication and the essence of nursing (p2790).

Patient literature appeared to align compassion with the actions of care. However, whether compassionate care could be formally taught or measured has been debated (Muncer et al., 2015), again suggesting the amorphous nature of the term. Richardson et al (2015) in their review of the literature argued that compassionate care could be taught throughout healthcare training. In contrast,

Bray et al (2014), in their mixed methods study with pre-registration (n=197) and qualified (n=155) health professionals, concluded that the role of health education in the teaching and provision of compassionate practice was unclear. Von Dietze and Orb (2000) argued that compassion is not merely an emotional connection that nurses establish with their patients; instead they proposed that compassion is a moral virtue, based on rationale thought and evaluation rather than sentiment alone. Tuckett (1998) supported this view identifying that as a moral virtue it provides context and direction to nurses' decisions and actions. Likewise, Shantz (2007) wrote *'that the time concept of compassion is elusive to the profession of nursing and the moral dimension has been eroded to such a degree that it could be considered an optional component of nursing practice'* (p48). Hence, time may be a factor preventing the delivery of compassionate care, in the sense of needing to nurture the nurse-patient relationship. Conversely, factors reported within the reviewed literature as enabling the delivery of compassionate care included support from colleagues, good team working and reflection (Firth-Cozens & Cornwell, 2009).

IV) Compassionate care delivery

Much of the literature located focused on the delivery of compassionate care (Tierney et al, 2017; Valizadeh et al, 2016; Christiansen et al, 2015; Muncer et al, 2015; Bramley & Matiti, 2014; Cole-King & Gilbert, 2011; Firth-Cozens & Cornwell, 2009; Darren-Thompson & Ciechanowski, 2003). It highlighted that views of compassionate care and how this is experienced across healthcare may vary (Tierney et al, 2017a; Papadopoulos et al, 2016; Tierney et al, 2016). For example, Tierney et al (2017a) conducted a grounded theory study, focusing on the meaning of compassionate care for healthcare professionals working with patients with Type 2 Diabetes. Using a mixture of interviews (n=13) and four focus groups (n=23), they found that compassionate care might be constructed in different ways within differing environments based on the individual's appraisal of a situation. Tierney et al (2017b) also outlined how compassionate care was provided along a continuum and *'affected by a complex range of interpersonal and organisational defenders and drainers'* (p9); defenders were defined as supportive colleagues, a compassionate culture and drawing from one's faith,

whilst drainers were defined as competing demands, tricky interactions with patients and personal difficulties.

If nurses are delivering compassionate care, and faced with various '*defenders and drainers*', following appraisal of a situation, it became important to note another section of literature which focused on what nurses gain from delivering compassionate care, as this may impact upon the appraisal of a situation.

V) Compassion satisfaction

For nurses, compassion satisfaction can occur, whereby they encounter gratification from caregiving (Simon et al, 2005). Literature suggests that caregivers feeling compassion satisfaction are less likely to experience compassion fatigue due to their ability to empathise and relieve suffering without becoming emotionally overwhelmed (Figley, 1995; Hooper et al, 2010; Rossi et al, 2012). Literature also identified a positive relationship between compassion satisfaction and job satisfaction (Utrainen & Kyngas, 2009; Laschinger et al, 2009), and a sense of nurse empowerment and improved patient safety outcomes (Armstrong et al (2009).

Cole-King and Gilbert (2011) wrote that delivering compassionate care could enhance staff efficiency, elicit better patient information and inform treatment plans; however, these statements were not based on evidence. Nevertheless, compassionate care has been promoted because of its proposed association with better patient recovery rates and increased satisfaction of the patient with the service and job satisfaction for the staff (Stewart et al, 2000; Di Blasi et al, 2001; Halpern, 2001; Larson & Yao, 2005; Youngson, 2012). Benner (1984) focused on the perceived healing abilities of compassionate care, arguing that nurses achieve this by mobilising hope, confidence and trust between them and their patient. This view was supported by Stoter (1995), who stated that if confidence and trust are created then a patient's spiritual and emotional needs can be more effectively addressed. Likewise, Koerner (1995) wrote: '*compassion truly directed outward is the foundation for transcendence of who and what we are*' (p317).

The above literature placed a focus on personal responsibility and ownership when considering the compassionate relationship between a clinician and their patient; this also appeared the case when considering the impact on the self.

A focus on personal responsibility and ownership to nurture the self was noted by Rossi et al (2012), who conducted a questionnaire study with Italian mental health workers (n=260). They found psychological distress increased the likelihood of compassion fatigue and burnout and reduced compassion satisfaction. However, they did recommend a longitudinal study be carried out to determine causality for factors related to the measured variables. They also felt that the inclusion of further variables, such as personal coping styles, would have been useful, placing the focus on individual themselves in taking ownership for their own wellbeing.

VI) Positive relationships and empowerment

Utrainen and Kyngas (2009), in their review of literature, found that positive interpersonal relationships and quality care have been associated with higher levels of job satisfaction. Laschinger et al (2009), in a questionnaire study with newly qualified nurses (n=205), supported this view, identifying that when nurses work in collegial, supportive environments, job satisfaction improves and the risk of burnout diminishes, reinforcing the role of a supportive environment in compassionate care delivery. Likewise, Armstrong et al (2009), when testing a theoretical model of empowerment with nurses (n=300), explored the relationship between workplace environment and sense of empowerment and found a positive correlation between nurse empowerment and better patient safety outcomes. They also noted that empowerment of nurses is associated with strong nurse leadership. The above literature reinforces the need for empowerment, ownership and supporting each other in order to improve compassionate care delivery, increase compassion satisfaction and mitigate the more negative consequences of caregiving. Potentially negative outcomes, like compassion fatigue and burnout, which have been associated with the delivery of compassionate care, are discussed in more detail in the next section and are summarised in table 10.

VII) Barriers and consequences to providing compassionate care

Many barriers to the delivery of compassionate care have been reported, including targets, time demands, paperwork and various aspects of organisational culture (Leebov & Ersoz, 1991; Orb, 1992; Koerner, 1995; Darren-Thompson & Ciechanowski, 2003; Christiansen et al, 2015; Valizadeh et al, 2016; Tierney et al, 2017). When considering barriers and consequences to the delivery of compassionate care, literature focused on a number of terms: Compassion fatigue, burnout, vicarious traumatising, secondary traumatic stress disorder and emotional labour. These terms were presented as barriers but also as the consequences that may be experienced of being exposed to the difficult aspects of nursing care, or meeting organisational expectations without acknowledging the impact on the self. In relation to this thesis it was felt that these terms were important as self-compassion and self-care may provide a means of preventing or managing these consequences. Table 10 outlines definitions for these terms in relation to compassionate care delivery:

Table 10: Definitions of related terms

Compassion Fatigue	A broad emotive term, which incorporates a number of occupational stressors that impact on the ability to provide compassionate care, due to a gradual reduction in compassion over time (Joinson, 1992; Sinclair et al, 2017).
Burnout	Defined as a phenomenon whereby the cumulative effects of work related stress might overwhelm staff members defences, subsequently forcing them to psychologically withdraw. (Hare et al, 1988).
Vicarious Traumatisation	When working with trauma patients, healthcare professionals may be impacted upon psychologically, with possible severe and lasting effects (McCann & Pearlman, 1990).
Secondary Traumatic Stress Disorder	Healthcare professionals and caregivers will indirectly experience the trauma of their patients (Figley, 1995; Kanter, 2007)

Emotional Labour	Defined as an induction or suppression of feeling in an attempt to sustain an outward appearance, to enable others to feel a sense of being cared for in a convivial, safe place (Hochschild, 1983).
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VIII) Business like culture

The move towards a business led model of care has been perceived as a barrier to compassionate care. Leebov and Ersoz (1991) proposed that when decisions regarding patient care are made mainly on the basis of cost then compassionate care is likely to suffer. Likewise, Duffield et al (2009) noted that the adoption of business models within healthcare has meant that nurses often spend less time with patients; however, I was unable to find evidence to support this claim. Valizadeh et al (2016) did conduct some empirical work to look at the barriers to compassionate care with a nursing population (n=15) in Tabriz (Northwest of Iran). They used a qualitative exploratory design, involving a small sample recruited from a single setting. The main theme emerging from their analysis was ‘unsupportive organisational culture’, with a focus on excessive workload combined with inadequate staffing and a lack of value being placed on compassionate care. The setting in which healthcare professionals work was likewise identified as important by Christiansen et al (2015), who explored the enablers and barriers to delivering compassionate care in a mixed method study. Through interviewing and responses to a non-validated questionnaire, with a population of health professionals (n=155) and healthcare students (n=197), their key finding was that *‘compassionate care requires an environment that facilitates compassionate relationships and supports the emotional health and wellbeing of the team’* (p837). Like Valizadeh et al. (2016), their study was conducted in a single setting, with all participants undertaking academic courses; therefore, findings may not reflect the views of a wider healthcare population. However, these studies provide a consistent message that the organisation and culture within which nurses work appear to play a key role in delivery of compassionate care, with changing systems, changing practices and reduced resources placing a high level of pressure on nurses’ ability to do so (Orb, 1992).

The literature therefore suggest that nurses may often find themselves facing numerous demands and are working in an unsupportive environment, leading to a question of how they perceive and manage the emotional components of their day to day work.

VIV) Emotional labour and emotional work

Work carried out in a healthcare setting can, by its nature, be an area of heightened emotions. If these emotions are not managed and processed, this can act as a barrier to compassionate care. Research on emotional labour has contributed to an understanding of the crucial role emotion management plays in many work settings (Smith, 2012). McCreight (2005) stated that nursing involves both emotional labour and emotional work, with emotional work consisting of the ability to regulate emotions (Hochschild, 1979). Research by Theodosius (2006) reported that connecting with the patient was important in the care-giving process but also in managing the emotions of caring. This ability for nurses to hold competing emotions is at the centre of a number of studies focusing on the emotional labour of nurses in different clinical settings (Allan & Smith, 2005; McCreight, 2005; Hunter & Smith, 2007; Gray, 2009).

A well known piece of work that contributes to understanding emotions in nursing is by Menzies Lyth (1960), who proposed that nursing staff dehumanise and distance themselves from patients in an attempt to cope with anxieties raised as a consequence of working with the ill or dying. After conducting a four year ethnographic study within a hospital setting, Menzies Lyth (1960) argued that nurses employed unconscious defence mechanisms to cope with difficult situations and distress and that the organisation failed to provide sufficient reassurance in such situations. The act of dehumanising and distancing creates a barrier to compassionate care delivery, and suggests that more positive coping strategies are required to enable nurses to manage difficult situations and the distress that can be associated with care-giving.

Mackintosh (2007) explored how nurses cope with working in surgical areas. She conducted a descriptive, qualitative study using interviews (n=16), although a specific methodological approach was not delineated. Three key themes

emerged; relationships with patients; being a person and; the effect of experience. She concluded that working as a nurse results in exposure to potentially distressing and stressful events from which it is important to protect the self, with this being achieved through the process of adopting a work related persona and the process of switching off. Mackintosh (2007) also wrote about adopting a work persona, or professional identity, to manage the emotions presented by patients, but doing so does not clarify how these emotions are processed. Hence, the existing literature does not appear to consider how nurses care for themselves; rather suppression of emotion or adoption of a particular persona to provide the compassionate care is proposed. The constant suppression of often powerful emotions can increase the likelihood of burnout (Gray & Smith, 2009; Pisanello et al, 2012), reinforcing the need for further intervention to enable nurses to care for themselves.

X) Compassion fatigue and burnout

Historically, compassion fatigue has been studied in populations other than nursing (Yoder, 2010); however, interest in this phenomenon within the realm of nursing has increased over the past twenty years (Boyle, 2011), suggesting a possible rise in its experience within this profession, or perhaps it has become a more recognised concept.

The depletion of compassion and the idea of '*having nothing left to give*', links to the term 'compassion fatigue', which was first introduced by Joinson (1992) who investigated the nature of 'burnout' among nurses in a busy emergency department. Joinson (1992) concluded that nurses '*seemed to have lost their ability to nurture*' (p 119). In a later piece of work, Sinclair et al (2016) conducted a meta-narrative review and concluded that compassion fatigue represents an emotive euphemism incorporating a broad group of occupational stressors specific to healthcare providers. Ledoux (2015) in her discussion paper explored the understanding of compassion fatigue by reviewing literature on it over a twenty-year period (1992-2002). She found that in order to understand compassion fatigue, a greater understanding of the antecedents, effects and prevalence of compassion is required. She also questioned whether compassion

is a limited resource, with compassion fatigue occurring when the supply of compassion is depleted.

Sabo (2006) defined compassion fatigue as a severe malaise resulting from caring for patients encountering physical, emotional and/or social pain. It can occur when nurses have close interpersonal contact with a patient who is suffering and their own emotions can blur causing assimilation with the patient's distress (Bush, 2009). Boyle (2011) acknowledged that nurses are at particular risk of compassion fatigue, as through the act of compassionate care giving they become partners rather than observers in a patient's journey within healthcare. Following a review of the literature, Boyle (2011) advised that compassion fatigue requires more deliberate attention from managers, educators, researchers and nurses themselves.

Hooper et al (2010) conducted an exploratory study, using a cross sectional design, with American general nurses (n=109) from four departments (emergency, intensive care, nephrology and oncology). The authors hypothesised that compassion fatigue and burnout would be higher for emergency staff compared with other departments, yet this was not the case. They found lower compassion satisfaction scores for emergency staff, a higher risk of compassion fatigue in oncology and a higher risk of burnout in intensive care. They concluded that *'nurses regardless of specialty are at risk'* (p426). Hooper et al (2010) noted that the majority of nurses perceive themselves as caring people but find it extremely hard to nurture themselves. This suggests that compassion outwards may be experienced as easier to access than self-compassion. The main limitation of this study was a single time point for the data collection, although the survey was delivered twice to potential participants, presumably to try and increase the response rate.

One of the factors associated with compassion fatigue and burnout is an individual's commitment to the organisation within which they work. Li et al (2014) studied the impact of group cohesion and organisational commitment as protective factors for a nurse's job satisfaction, compassion fatigue, compassion satisfaction and burnout. They conducted a quantitative study with 251 US nurse

residents, at two time points (one month and three months into the nurse residency programme). It is not clear why these two time points were chosen and it could be argued that longer between time point one and two would have been useful in order to provide the nurses with more clinical experience. They concluded that group cohesion was an effective protective factor in reducing the effects of stress and burnout, whilst improving compassion satisfaction. They also found that organisational commitment was not a protective factor from negative outcomes but it did help to promote job satisfaction. In contrast to Li et al (2014), other research has suggested the importance of organisational factors with regard to reduction of the more negative effects of caring (Armstrong et al, 2009; Laschinger et al, 2009; Utrinen & Kyngas, 2009). This may be due to variation in populations or the types of measures being used in different studies and also highlights the possible role for qualitative research and the exploration of experience and meaning, rather than a reliance on self-report measures.

A systematic review of the literature (Lee et al, 2012) explored whether compassion can be taught to decrease compassion fatigue and to raise healthcare standards. It concluded that compassion is a subjective emotion that is challenging to define, as previously noted in this chapter, and highlighted that innovative ways must be sought to enhance compassionate care. They indicated that by improving communication skills, self-compassion and the ability for self-reflection, clinicians could determine when compassion was in danger of becoming fatigued. This indicates a potential relationship between self-compassion and reduction in compassion fatigue. However, it was difficult to ascertain whether their recommendations were based on opinion or were born from the literature.

XI) Secondary traumatic stress and vicarious traumatisation

When reviewing the literature two other terms featured - secondary traumatic stress and vicarious traumatisation. Within the literature they were often used alongside compassion fatigue and burnout or as related terms. This led to confusion and a lack of definition as to whether they are all interconnected or stand alone concepts, although some attempts at clarification were made within the literature. For example, Figley (1995) identified that compassion fatigue was

a more user-friendly term to describe secondary traumatic stress disorder (STSD), whereby empathic caregivers indirectly experience the trauma of their patients (Kanter, 2007).

The following symptoms of secondary traumatic stress are reported by Gentry et al (2002), *'increased negative arousal, intrusive thoughts / images of another's critical experiences, difficulty separating work from personal life, lowered frustration tolerance, increased outbursts of anger or rage, dread of working with certain individuals, depression, ineffective and / or self-destructive self-soothing behaviours, hyper vigilance, decreased feelings of work competence, diminished sense of purpose / enjoyment with career, lowered functioning in non-professional situations and loss of hope'* (p.126). This exhaustive list goes some way to explain the risk factors faced by nurses when exposed to traumatised patients or traumatic events and add to the argument for protective factors such as self-care and self-compassion to be in place.

The term 'vicarious tramatisation' was first attributed to McCann and Pearlman (1990) to identify that working with trauma victims may cause severe and lasting psychological effects. Saakvitne and Pearlman (1996) suggested that vicarious traumatisation can lead to changes in both self and professional identity, one's view of the world, spirituality, self-capacities, psychological needs and beliefs particularly relating to safety, trust, esteem, intimacy and control. Blair and Ramones (1996) also reported an increased risk of developing full Post Traumatic Stress Disorder (PTSD), if left without treatment or intervention. Sabin-Farrell and Turpin (2003) in their review of the literature found only a small number of empirical studies relating to vicarious traumatisation, based on the narratives of therapists (Iliffe & Steed, 2000; Sexton, 1999). They concluded that their review provided little consistent evidence for vicarious traumatisation but there were clear identifiable effects of trauma work on clinicians. They proposed further investigation particularly within the general health care system.

At present, research has involved therapists directly working with trauma or providing trauma focused treatment (Sabin-Farrell & Turpin 2003; Elwood et al, 2011; Crumpei & Dafinoiu, 2012); however, nurses often face traumatic, distressing events that can cause symptoms consistent with this and, if left

untreated, can impact on nurses staying within the profession (Currie & Carr Hill, 2012). Dominguez-Gomez and Rutledge (2009) used quantitative methods to explore the prevalence of secondary traumatic stress amongst US emergency nurses (n=67) and found 85 percent reported at least one symptom consistent with secondary traumatic stress in the past week, with 33 percent meeting the full diagnosis. They recommended the need for healthcare organisations and leaders to increase awareness of secondary traumatic stress and to develop effective strategies to ameliorate these symptoms. Limitations of the study were use of self-report measures and sampling from a single geographical location, highlighting a need for further study.

Some professionals have argued for interventions and an increase in resources devoted to the prevention and treatment of secondary trauma symptoms (Pearlman & Saakvitne, 1995; Tyson, 2007). Munroe (1999) made a case for specific training in clinician self-care for those considering working with trauma populations. This is of relevance to the current study due to one of the core aims being to focus on the experience of self-care within the nursing population. Salston and Figley (2003) supported this notion of the importance of self-care by identifying the need for clinicians to engage in self-care activity, to monitor their own schemas (pattern of thought and behaviour), and to balance professional and personal activities. The issue of professional leadership was also highlighted in the literature, with organisations and leaders called upon to adopt prevention and treatment interventions such as limiting case loads, supervision, staff support time, increased periods of leave and access to mental health support (Rudolph & Stamm, 1999). Yet this may be difficult within the current climate of the NHS.

XII) Nurses being ill prepared for practice

Some research has been completed with student nurses suggesting they feel ill prepared for the emotional demands of nursing practice (Maben & Macleod Clark, 1998; Allcock & Standen, 2001; Freshwater & Stickley, 2005; Hunter & Deery, 2005; Maben et al, 2007; Lavoie-Tremblay et al, 2008; Rudman & Gustavsson, 2011; Msiska et al, 2014; Jack & Wibberley, 2014). Burnout has also been identified as an occupational hazard, which can have a negative impact on newly qualified nurses (Laschinger & Fida, 2013; Laschinger et al, 2012).

Jourdain and Chenevert (2010) found that burnout, in particular emotional exhaustion, plays an important role between stress factors relating to the work conducted by a nurse, the nursing environment and the intention to leave the profession.

Jack and Wibberley (2014) suggested emotional engagement might be facilitated if student nurses are able to discuss their emotions. They placed a focus on the need for positive role models whose emotional coping style can be emulated. Research conducted by Maben and Macleod Clark (1998) also centred on the importance of role models and a supportive environment. They conducted a small scale (n=10) qualitative interview study using a narrative approach with newly qualified nurses. Maben et al (2007) further explored the experiences of newly qualified nurses (n=72) in a longitudinal study using questionnaires and interviews. This research found that after a two year period, the majority of participants experienced frustration and some level of burnout as a consequence of their previous ideals about nursing being thwarted. Another longitudinal study completed by Rudman and Gustavsson (2011) with Swedish nurses (n=1153) similarly found newly qualified nurses to be at risk of burnout and exhaustion. These findings are supported by the work of Lavoie-Tremblay et al (2008) whose research focused on newly qualified nurses in Quebec. They identified that 43.4% of their sample reported high levels of psychological distress and a perceived imbalance of effort expended at work versus rewards received. They noted links with high psychological demands, high job strain and a lack of social support from their colleagues and superiors. Ernst et al (2004) also found that newly qualified nurses are at increased risk of job stress, noting that job stress is inversely related to age, years as a nurse, and years in an organisation.

Freshwater and Stickley (2005) recommended preparing student nurses for the realities or difficulties of practice through the incorporation of teaching within the nursing curriculum that focused on emotions and their potential impact. They argued that it should be an essential requirement, acknowledging the significance of emotions in healthcare. Furthermore, Laschinger et al (2015) proposed that effective and authentic leadership could strengthen new nurses' confidence and thus protect them from burnout. However, Coetzee and Klopper (2010),

following completion of a concept analysis, concluded that further studies are required to develop interventions to prevent or reduce compassion fatigue and burnout. Garrosa et al (2011) studied the impact of role stress and personal resources on burnout and engagement, concluding that if nurses possess optimism, a hardy personality and emotional competence, the risk of burnout is lowered. They also discovered that nurses who were more optimistic reported lower levels of exhaustion and higher levels of vigor and dedication. Hooper et al (2010) stated that self-care is important when thinking about the prevention of compassion fatigue, and noted this conflicts with a sense of nurses having an intrinsic calling to care for others, often to the detriment of their own emotional and physical needs.

XIII) The tension between an individual and organisational view

The overview of literature above shows a tension between an individual and an organisational view, with regards to compassionate care. A position paper completed by Crawford et al (2014) explored the design of compassionate care, through a review of existing literature over a thirteen year period (2000-2013). They identified that acknowledgement of how systems and structures within healthcare can impede compassion has already been established. Less is known about how organisations can promote compassionate care, although researchers have started to explore this topic (Tierney et al, 2017). Crawford et al (2014) did suggest '*a critical aspect of compassionate design could be the implementation of changes to the physical environment, the language and culture, as well as work processes so as to reduce the prominence of production-line and threat mentalities*' (p3596). The same authors qualitatively, through use of semi-structured interviews, explored these ideas with twenty mental health practitioners, in a study focusing on the language of compassion in acute mental health care (Crawford et al, 2013). They found little discussion of compassion in the interviews, despite this being the main topic of interest. They noted how a production line mentality '*intruded into the discourse of the practitioners*' (p7), and the language used by the participants '*indicated both an institutional mentality and emotional distancing between practitioners and patients despite concern for delivering a quality service*' (p7). This was a small study and one of

the key authors, Paul Gilbert, features heavily within the compassion literature and therefore may be providing a particular viewpoint, although it can be argued that all individuals who enter the field of research have their own viewpoint and assumptions.

Work by Sawbridge (2016) placed attention on nurses holding a duty of care to their patient and a responsibility as an employee to their organisation. She stated *'when these are in tension... it compounds the levels of emotional labour nurses are required to deliver. This has an impact on the ability of staff to provide compassionate care for patients; if their 'emotional bank account' is overdrawn, they may have nothing left to give'* (p.139). This suggests the need to be aware of and manage emotions to avoid depletion of compassion in practice, in line with Smith's (2012) proposal that nurses should work emotionally on themselves in order to care for their patients.

XIV) Summary

Healthcare policy highlights a need for the delivery of compassionate care by nursing and clinical staff. Much of the existing literature and research has tried to define compassionate care, with many authors noting that this is difficult and challenging to communicate. The meaning of compassionate care may vary, although it is clear that patients want compassionate nurses and nurses feel a duty of care to provide this. Compassionate care focuses on collaboration in the patient journey and suggests a responsibility by individuals, teams and organisations. However, there is a question on how far the nurse enters into the patient journey. The literature is consistent in identifying that compassionate care results in improved patient care and satisfaction, and also brings benefits for nurses, such as compassion satisfaction. It is important to note that nurses appear to wish to provide compassionate care; however there may be barriers to this, including time demands, the move towards a business led model of care and various aspects of organisational culture.

The literature suggests student nurses and newly qualified nurses are ill prepared for both the realities of practice and managing associated emotions. Research on

emotional labour highlights a tension between how nurses show and experience emotions versus how an organisation wants them to be portrayed. This reinforces the need for further exploration of how nurses care for themselves to cope with these demands on their emotional equilibrium.

Research focusing on compassion fatigue and burnout suggests a number of possible links to self-care and self-compassion and how these may improve or prevent it from occurring. Further exploration within the nursing population is required on how these phenomena are experienced and whether self-care and self-compassion can be used as a preventative measure or whether they are useful if a nurse is already 'fatigued' or 'burnt out'.

Nurses face difficult, often traumatic situations and traumatised patients on a regular basis and are clearly at risk of secondary stress symptoms according to the research. Much of the research conducted proposes the importance of early identification of these symptoms and early intervention by an organisation. There is also recognition for prevention by developing resilience and promoting self-care in nursing staff. Much of the research has been conducted within therapy populations. This supports a place for my study, which aims to fill the gap in knowledge by looking at how self-care and self-compassion are experienced by nurses within their current working environments and in relation to the often difficult, traumatic situations they face, in which they are expected to deliver compassionate care.

2.5 - Literature review summary

For the purpose of my study it was vital to explore what was known within the literature and what was missing, in order to formulate my research questions and to justify my research. This review of the literature has revealed that compassion itself is defined in a consistent manner and is expected from a nurse; it remains unclear from the literature whether compassion is a trait or can be learnt. The above literature suggests that self-compassion may be used as a means of helping to understand and manage some of the more difficult emotional aspects of nursing, improving motivation, enhancing the compassionate relationship with the patient, and as a tool to reduce the risk of compassion fatigue and burnout.

The existing literature suggests that self-compassion positively relates to wellbeing, improved life satisfaction, emotional intelligence and more effective coping strategies. However, it is not known how self-compassion is experienced in everyday nursing practice, how it can be cultivated, and the barriers to nurses using self-compassion.

Much of the health related self-care literature places a focus on promotion of self-care for patients without looking at the nurse's own ability to be self-caring. It is unclear how nurses engage with self-care, and their views on its importance. The literature described a number of interventions currently linked to nursing – supervision, Schwartz rounds and mindfulness - that are proposed to help nurses process and manage their emotions and become more resilient practitioners. However, it is unclear how nurses perceive and experience their own self-care individually and within the nursing and healthcare culture. The literature proposes a link between self-care, self-compassion and compassionate care giving, but there is a lack of data exploring self-compassion and self-care in nursing and how this might influence the delivery of compassionate care.

When thinking about compassionate care more specifically, this can be compromised or strained by various internal and external factors. It is difficult to ascertain from the literature how nurses experience such tensions and how this can be changed within nursing practice. The need to deliver compassionate care exists within the current healthcare context, current legislation and nursing guidelines, however the literature suggests a number of barriers to this. The provision of compassionate care appears as a responsibility of both the nurse, the team and the organisation and is expected by patients. The literature reviewed suggests that delivering compassionate care is not adequately addressed in nursing education, and that nursing students and newly qualified nurses feel ill prepared to manage the realities of a nursing role.

Nurses are at risk of some of the more detrimental side effects of nursing and being exposed to difficult situations, including trauma, such as; burnout, compassion fatigue and being vicariously traumatised. Thus, there appears a need

to enable nurses to care for themselves proactively as well as reactively to mitigate some of these side effects.

Overall, this review of the literature supports the need for a greater understanding of how nurses experience self-compassion, self-care and how these may relate to compassionate care giving on an individual level and within the wider healthcare context and culture. If this understanding can be achieved then this new knowledge may support the nursing workforce to be able to care for itself alongside providing quality, compassionate care towards their patients. In order to explore these ideas and to develop a model or theory that may inform nursing practice, it is important to note that multiple perceptions will exist, with nurses viewing the above concepts from their own unique perspective. Alongside this, many of these perceptions or realities will occur in different contexts and are likely to encompass a number of social interactions and social processes. This, alongside my own position as a nurse, lends itself to the chosen methodology of Constructivist Grounded Theory.

Whilst the literature review provides valuable insights, it does not answer my research questions or suggest that a different methodological approach is needed other than the suggested Constructivist Grounded Theory approach, which is further explored in the following chapter.

CHAPTER 3: **METHODOLOGY AND METHODS**

Part One: **Philosophical and Methodological Framework**

3.1 – Introduction

Chapter two reviewed the literature relating to self-care and self-compassion within the field of nursing. It remains unclear how nurses experience self-care and self-compassion and how this relates to care giving. This study thus aimed to explore the following:

- What are nurses' experiences of self-care and self-compassion?
- How do these experiences relate to compassionate care giving?

This chapter outlines the rationale for adopting and following a Constructivist Grounded Theory approach as the study's philosophical and methodological framework (Charmaz, 2014).

3.2 – Consideration of the research paradigm

Paradigms are sets of beliefs and practices, often shared by communities of researchers, which guide and shape inquiry within disciplines (Weaver & Olson, 2006). They can also be viewed as an underpinning model, pattern or approach to research (Denicolo et al, 2016). A paradigm directs and informs what research topics may be investigated, how research is conducted and how theories are derived (Monti & Tingen, 1999). Weaver and Olson (2006) identify the paradigms used for nursing research as positivist, postpositivist, interpretive and critical social theory. Positivism is based on rigid rules of logic and measurement, truth, absolute principles and prediction (Weaver & Olson, 2006). Postpositivism emerged as a result of the realization that reality is not fully known and understood, but rather that the attempts to measure it are based more around human understanding (Guba & Lincoln, 1994). Hence, postpositivists accept that human knowledge and values can influence what is being observed or measured. The interpretive paradigm focuses on relationships and understanding meanings

linked to actions, with a recognition and collaboration between the researcher and research participant (Horsfall, 1995). Gillis and Jackson (2002) define critical social theory as a study of social institutions, issues of power and alienation, whereby realities are seen as shaped by social, political, cultural, gender and economic factors (Ford-Gilboe et al, 1995). Constructivism aligns itself with interpretivism; seeking to understand people's meanings at an individual level, whilst maintaining a recognition that this understanding may always be subject to interpretation (Crotty, 2003).

When considering the most appropriate paradigm I took into account the aim of the study, the research questions being explored and the type of knowledge required. I outline the relevance of the positivist and post positivist paradigms to the current study before explaining why I believe the constructivist paradigm is best suited to the study.

3.3 - The positivist paradigm

The term positivism was developed by the French philosopher Auguste Comte (1798-1857) (Schwandt, 2001). The positivist paradigm perceives 'knowledge' as identifiable, objective and therefore measurable. It proposes that *"there is a reality out there to be studied, captured and understood"* (Denzin & Lincoln, 2000, p9), and asserts that those things that exist can be described factually (Denicolo et al, 2016). Gray (2004) states positivism argues that:

- *Reality consists of what is available to the senses – that is, what can be seen, smelt, touched, etc.*
- *Inquiry should be based upon scientific observation (as opposed to philosophical speculation), and therefore on empirical inquiry.*
- *The natural and human sciences share common logical and methodological principles, dealing with facts and not with values. (P21)*

Taking a positivist stance would mean arguing that the social world exists externally to the researcher (Gray, 2004). Within studies that adopt a positivist approach the researcher is regarded as independent from the study and there are no provisions within it for human interests, such as the values, experiences,

background and preconceptions of the researcher (Crowther & Lancaster, 2008). Hence, the potential influence the researcher has upon the study and the data collected is not acknowledged or explored. However, when conducting positivist research steps are often taken in designing the study to mitigate this. It is argued that assuming a positivist approach is associated with a belief that you are independent of your research and your research is purely objective (Kuhn, 1962). Due to the nature of the study presented in this thesis, the questions being asked and the position of the researcher as a nurse herself, a positivist approach was not considered appropriate. Applying the positivist approach to this study would not allow access to personal experiences in nursing.

3.4 – The Postpositivist Paradigm

The key influences in postpositivist philosophies and approaches were Karl Popper (Popper, 1959), Jacob Bronowski (Bronowski, 1950), Thomas Kuhn (Kuhn, 1970) and Charles Hanson (Hanson, 1958). Kuhn (1970) described a paradigm shift as postpositivism emerged, largely as a critique of positivism. Appleton and King (2002) proposed that both positivists and post positivists believe that an external reality exists and can be measured, but within postpositivism there is some acknowledgement that there are multiple realities that can be partially captured. Thus, this perspective holds that reality may be experienced in a similar way and that possible truths are discovered as opposed to a clear objective truth. Lincoln and Guba (1985) identified that within postpositivism, researchers cannot separate cause from effect, arguing this is due to the fact that they exist together.

Postpositivist researchers view inquiry as a set of logically related steps, believing in multiple perspectives gained from participants rather than a single reality (Cresswell, 2013). Postpositivists accept that theories, background, knowledge and values of the researcher can influence what is observed (Robson, 2002), thereby aligning itself with qualitative methodologies, although not exclusively. The researcher aims for a detached, objective position whilst recognising the possible effects of background knowledge and the context within which the study is being carried out.

As postpositivist researchers still aim for a detached, objective position, it was felt that this stance would not be suitable for my study and field of inquiry. When a study is guided by this approach, a mixed methods design may be undertaken, triangulating both qualitative and quantitative data. Consideration of a mixed methods design and approach is discussed later in this chapter (section 3.8).

3.5 - The constructivist paradigm

In this chapter I argue that the constructivist paradigm is best suited to this study, as it reflects a perspective where multiple realities exist. Charmaz (2006) identifies this in relation to each participant viewing a situation from a unique position. Constructivists propose that each individual has their own reality with a multitude of constructions that can occur concurrently.

In order to access participants perspective of the role of self-care and self-compassion, an exploratory approach, located within the constructivist paradigm, seemed appropriate; the term 'constructivist' acknowledges '*subjectivity and the researcher's involvement in the construction and interpretation of data*' (Charmaz, 2014, p14). When constructivism underpins a study, phenomena can be explored in their natural setting in order to understand how participants construct reality in a context where meanings are embedded in the actions they perform (Parahoo, 2006). The goal of the research was to explore participants' meanings (Creswell, 2013), with these subjective meanings being formed through interaction with others, and through historical and cultural norms in their lives, hence through social construction. The participants also acknowledged my role as a nurse and this held a bearing on how the data were constructed.

In postpositivist approaches researchers often start the research process with a theory, however within constructivism researchers are looking to generate or inductively develop a theory or pattern of meaning (Creswell, 2013; Lincoln & Guba, 2000). This approach often requires broad research questions to define the field of study and the use of open ended questions when gathering data, both of which this study adopts. I also acknowledged my own background and experience and recognised the position I took within the field of study as the data were collected and analysed.

3.6 - Qualitative Methodologies

Qualitative research is increasingly popular within health research (Sbaraini et al, 2011), with a growing recognition of its utility in exploring health issues (Campbell et al, 2000; Dingwall et al, 1998; Turpin et al, 1997). Qualitative methods enable the study of issues in-depth (Patton, 2002), and represent a *‘complex, interconnected family of terms, concepts and assumptions that cut across disciplines, fields and subject matter’* (Denzin & Lincoln, 1994, p3).

McCrae and Purcell (2016) note that as a human endeavor, nursing has a strong tradition of qualitative enquiry. The collection of rich experiential data provides a starting point for the investigation of previously under researched topics, particularly where complex thoughts, emotions and meanings are likely to be involved (Barker et al, 2002). When using qualitative research, certain assumptions are made, consisting of a stance towards the nature of reality (ontology), how the researcher knows what she knows (epistemology), the role of values (axiology), language (rhetoric) and the methods used (Creswell, 2003; Creswell, 2007).

Qualitative methods are compatible with a variety of epistemological frameworks on a realist/ constructivist continuum (Madill et al, 2000; Schwandt, 2003). The key principles of qualitative research within the constructivist paradigm are:

- to tap into the subjective personal accounts of individuals (Schwandt, 2004)
- to shed light upon: *‘phenomena in terms of the meanings people bring to them’* (Denzin & Lincoln, 2013, p13)
- individuals seek understanding of the world in which they live and work, and develop subjective meanings of their experiences (Cresswell, 2013)
- the inclusion of the researcher’s knowledge and experience of the research area (Charmaz, 2014)
- co-construction of data: *‘both the researcher and the participant together generate meaning for example’* (Denzin & Lincoln, 2003, p35)

-there are many different views of ‘reality’ in terms of what constitutes ‘knowledge’ (Denzin & Lincoln, 2003)

Locke (2001) links qualitative research to a ‘bewildering’ array of paradigms, which incorporates a number of strategies and approaches (Creswell, 2003) and theoretical orientations (Patton, 2002). Holton (2008) acknowledges the divergence of perspectives, but reinforces the need for qualitative research to attempt to understand the nature of truth as a basis for generating knowledge through research. However, how is this ‘truth’ perceived within social constructivism? Charmaz (2006) identifies that ‘truth’ means a true picture of processes and meanings, placing the focus on the socially constructed knowledge of the participants and the researcher. This encompasses the notion of multiple realities and co-constructed knowledge rather than a single ‘truth’. Roller and Lavrakas (2015) propose that qualitative researchers focus on the plausibility of their findings as opposed to the ‘truth’. Denicolo et al (2016) propose that a person’s ‘truth’ is individually defined. This acknowledges the role of subjectivity and social context in the production of knowledge (Madill et al, 2000). The principles of the constructivist paradigm are to look into the subjective personal accounts of individuals (Schwandt, 2004) to explore ‘*phenomena in terms of the meanings people bring to them*’ (Denzin & Lincoln, 2003, p13), to acknowledge the researcher’s knowledge and experience of the research area (Schwandt, 2001) and to reflect on how this might shape interpretation of the findings.

Participants will have their own experiences related to self-care and self-compassion, and it is these experiences that this study sought to explore, uncover and co-construct through the process of in-depth interviews. Charmaz (2014) notes that constructivism assumes the relativism of multiple social realities. Charmaz (2014) also recognises the mutual creation of knowledge between the researcher and participants.

3.7 – Consideration of alternative qualitative methodologies

A consideration of other qualitative methodologies is useful before I discuss the methodology used for this study, to account for why other approaches were not used.

3.7.1 – Phenomenology

There are two main strands to phenomenology: ‘transcendental phenomenology’ developed by Edmund Husserl (1838-1959) as an alternative to the empirically based positivist paradigm, and ‘hermeneutic phenomenology’ by his pupil Martin Heidegger (1889-1959) (Van Manen, 1990). Heidegger developed his own approach due to concerns regarding the original angle posited by Husserl (McConnell-Henry et al, 2009). Husserl in transcendental phenomenology believed that to fully expose ‘lived experience’ it was necessary for any preconceived ideas to be put aside (Stumpf & Frieser, 2008), and achieved this through the use of ‘bracketing’. Heideggerian hermeneutic phenomenology was in contrast to this, with Heidegger being opposed to ‘bracketing’ instead recognising the researcher as a legitimate part of the research and thus bringing prior knowledge and understanding.

Neither Husserl nor Heidegger set out to produce methodologies but rather philosophies, which have since been used as frameworks to underpin methodologies (McConnell-Henry et al, 2009). Phenomenology focuses on the common meaning for several individuals of their lived experiences of a concept or a phenomenon (Cresswell, 2013). The researcher collects data from people who have experienced the phenomenon, and develops a composite description of its essence for all of the individuals, consisting of what they experienced and how they experienced it (Moustakas, 1994).

Phenomenology is popular in the social sciences (Borgatta & Borgatta, 1992) and nursing and health science research (Nieswiadomy, 1993; Munhall & Oiler, 1986), being used in the pursuit of nursing knowledge development (Jones & Borbasi, 2004). It is often viewed as an alternative to empirical science, offering a means for understanding the lived experience (McConnell-Henry et al, 2009). Rapport and Wainwright (2006) suggest nurses turned to phenomenology to

explore patients' lived experience of illness.

Using a phenomenological approach for the study described in this thesis would have offered insights into the lived experience of self-care and self-compassion, but would not have explored the role of these in nursing or have enabled theoretical construction and development. The current study aimed to move away from description, towards interpretation and theoretical development in order to contribute to the knowledge base within this field.

3.7.2 - Ethnography

The foundations of ethnographic research lie in the field of anthropology, specifically the work of anthropologists such as Malinowski who conducted observational studies of non-western societies (Malinowski, 1922). Studies adopting an ethnographic method observe and question to uncover a sense of 'what is going on?' (Hammersley & Atkinson, 1983). An ethnographic study focuses on an entire culture-sharing group (Cresswell, 2013), to enable a researcher to describe and interpret the shared and learned patterns of values, behaviours, beliefs and language within the group (Harris, 1968). Ethnography involves extended observations of the group, most often through participant observation, with the researcher being immersed in the day-to-day lives of the participants (Cresswell, 2016). Ethnography has been criticised for its positivist traditions, for the length of time required to conduct an ethnographic study, for its approach to sampling and for its descriptions of participants' views and settings rather than processes and meanings (Charmaz, 2006), as constructed by the participants and the researcher in a context driven way. Charmaz (2006) offers Grounded Theory as a means of overcoming some of these issues.

Ethnography places a focus upon explaining participants' shared values and whilst a cultural understanding of self-care and self-compassion may prove useful, it is not the focus of the research questions posed within this study. Observation is key within ethnography, however this would unlikely capture the personal elements of self-care and self-compassion as these often encompass felt emotions as well as perceived behaviours.

3.8 - Consideration of a mixed method design

A mixed method design was initially considered in order to capture both quantitative and qualitative data. However, it was difficult to identify questionnaires that would complement the topics being explored. The following questionnaires were considered:

-Professional Quality of Life Scale (ProQol), (Stamm, 2005)

The Professional Quality of Life Scale is a thirty-item scale focusing on compassion satisfaction, burnout and compassion fatigue. The compassion satisfaction dimension measures pleasure derived from being able to carry out your work well, with higher scores representing a greater satisfaction relating to your ability to be an effective caregiver. The burnout dimension is associated with feelings of hopelessness and difficulties in dealing with your work, with higher scores indicating a higher risk of burnout. Finally the compassion fatigue dimension centres on work-related secondary exposure to extremely stressful events, with high scores indicating exposure to frightening experiences at work. This questionnaire covers some of the key areas addressed within the literature review and relating to the field of study. However, it was felt its use would place too much emphasis on these elements, and would provide no context for experiences unless used fully in conjunction with interview data. It was felt that interview data on its own would be more appropriate in capturing these personal experiences.

- Self-Compassion Scale (SCS), (Neff, 2003)

The Self Compassion Scale is a twenty-six-item scale, developed in order to measure a person's levels of self-compassion (thirteen items) and self-coldness (thirteen items). It is designed as a self-report measure with good construct validity (Neff, 2003; Mayhew & Gilbert, 2008). It was considered for this research, as it measures one of the main themes of interest. However, at present it is predominantly used with a patient population (Neff, 2003) and therefore validity and reliability among nurses is not established. It is also difficult to score and much argument has been held between Neff and other clinical and academic researchers as to whether the scale should be scored as a unitary or binary measure (Lopez et al, 2015).

-Nursing Stress Scale (NSS), (Gray-Toft & Anderson, 1981)

The Nursing Stress Scale consists of thirty-four items that describe situations identified as causing stress for nurses in the performance of their duties. It provides a total stress score as well as scores across seven subscales. Higher scores indicate more frequently experienced stress. This questionnaire was considered as it was anticipated that stress in nursing might be a theme, which emerged. However, once again it was felt that interview data would better capture emerging themes for the purpose and aims of this particular study and avoid focusing the participants on the concept of stress.

Using questionnaires can lead to a research gap in terms of capturing an individual's subjective experiences. Some researchers have recognised that not all phenomena, as is the case in this study, are conducive to measurement, with meaning often lost within a questionnaire that is fragmented into component parts (Annells, 1997). I felt that interviews would be the most appropriate method of data collection for this study to capture personal experience, allowing participants to be heard and listened to whilst they discussed these experiences. The following section will provide an insight into why the methodological approach chosen for this study was used.

3.9 - Why Grounded Theory?

Dingwall et al (1998) note that within health services research, Grounded Theory studies can be useful in contributing to the development of the efficiency and effectiveness of services, whilst acknowledging and retaining the human perspective. This can be achieved due to the generation of theory and concepts that have been co-constructed by the researcher and participants whilst collecting data relating to experiences and processes. Due to the field of inquiry and trying to understand the experiences of self-care and self-compassion in nursing it was anticipated that the Grounded Theory method would be useful in order to contribute a theoretical understanding of these phenomena within the healthcare setting.

Glaser and Strauss (1967) stated that Grounded Theory endeavours to discover the meanings people attribute to their experiences through the systematic

interpretation of rich data, whereby the overall goal of the analysis is to develop substantive theory, which is grounded in the data. This is carried out in a rigorous and detailed manner, to gain a deeper understanding of how the social phenomenon being studied operates (Ryan & Bernard, 2000). Glaser and Strauss (1967) identified that the researcher must approach the study inductively, with no preconceptions to prove or disprove and conceptualise the principle concern of the participants. They stated that all explanations or theories are derived from the dataset, rather than constructed from the researcher's viewpoint. Due to my nursing background and experience it is likely that I would embark on the study with preconceptions and ideas related to my research questions. The adoption of a constructivist Grounded Theory approach allowed for this, alongside the need for ongoing reflexivity. These points are further expanded upon later in the chapter.

Grounded Theory focuses on the understanding of social interaction and social processes. Within the concepts of self-care and self-compassion, social processes are an area of interest as these phenomena involve an individual but, as outlined in the literature review, are likely to be shaped by interactions with others and by environmental factors. Grounded Theory's inductive approach enables a greater understanding of this field of interest. Within the current literature base, as outlined in chapter 2, self-care and self-compassion are poorly defined within nursing, with a dearth of literature available. Therefore, it was anticipated that Grounded Theory would enable the clarification of concepts related to self-care and self-compassion, along with the social processes and meanings attributed to them.

3.10 - History of Grounded Theory

Grounded Theory was first defined as a discrete methodology by sociologists Barney Glaser and Anselm Strauss. Glaser's background comprised a rigorous training in quantitative methods and middle range theories, working at Columbia University, whilst Strauss had a background in symbolic interaction, derived from his studies with the Chicago School and its emphasis on pragmatist philosophy, social psychology and ethnographic field research (Bryant & Charmaz, 2007). In 1967 Glaser and Strauss produced their influential

publication, the Discovery of Grounded Theory, whilst they were working on a study exploring the awareness of dying at the University of California. During this research, they encountered and criticized the overemphasis of verifying theories to the detriment of actually generating theory (Glaser & Strauss, 1967; Moore, 2009). They argued that an over-reliance on the positivist paradigm led to impoverished theory development, as there were no universal truths to be discovered (Charmaz, 2006), while there were no robust qualitative methods to bridge the gap between grand theory and 'real world' data (McCrae & Purcell, 2016). At the time of Grounded Theory's development, the view most often held within research was that knowledge was 'true' or 'false' only if it had been tested and deemed a verifiable fact. Glaser and Strauss intended to offer an alternative to the idea that sociologists could only conduct research in the hope of 'verification' (Schwandt, 2001, p270). They argued that a theory might be discovered, with researchers therefore needing to enter the field of research devoid of preconceptions about what categories or hypotheses were likely to be of importance (Glaser & Strauss, 1967). Glaser and Strauss labeled their innovative methodology 'Grounded Theory' to encapsulate its overarching objective to ground theory in data (Kenny & Fourie, 2014).

The emergence of Grounded Theory was seminal to the development of qualitative research (Kenny & Fourie, 2014). It provides a foundation for rendering the processes and procedures of qualitative investigation visible, comprehensible, and replicable (Bryant & Charmaz, 2007). The foundations of Grounded Theory are rich and varied (Bryant & Charmaz, 2007), based on four founding texts by Glaser and Strauss: Awareness of Dying (1965), The Discovery of Grounded Theory (1967), Time for Dying (1968), and Status Passage (1971).

Glaser and Strauss (1967) identified that analysis within Grounded Theory may be used to develop two types of theory - 'substantive' and 'formal' (Glaser & Strauss, 1967); the former is more limited in scope and related to a specific population, such as self-care in nurses, whilst the latter is broader in scope, with the concept applying across several areas, such as self-care among care-givers. They proposed that theory should be 'grounded' in an iterative cycle of data

collection and analysis, with the aim being to discover subjective meanings placed on events and situations by individuals and groups (Glaser & Strauss, 1967). They aimed to provide a clear basis for systematic qualitative research.

Traditional Grounded Theory was founded on the premise of critical realism so ontologically is regarded as being postpositivist in its intent (Annells, 1997). However this methodology has since been adapted to fit with various ontological and epistemological positions (Mills et al, 2006), most notably constructivism (Charmaz, 2006, 2014), post modernism (MacDonald & Schreiber, 2001) and situational analysis (Clarke, 2005), although some Grounded Theorists still adhere to this paradigm. Glaser, in particular, has adhered to the initial description of the model (Glaser, 1978; 1992), whilst Strauss responded to novice researchers' desire for procedural guidance, particularly in analysis (McCrae & Purssell, 2016). Hence, Strauss and academic nurse Juliet Corbin developed new technical procedures, particularly regarding methods of coding (Strauss & Corbin, 1998). They introduced a prescriptive process of analyzing data after each interview, using a coding framework to verify concepts and inform further fieldwork (Strauss & Corbin, 1998). Strauss and Corbin also placed more of a focus on theoretical sampling (described later in this chapter), as a means to *'maximise opportunities to discover variation among concepts and to densify categories in terms of their properties and dimensions'* (Strauss & Corbin, 1998, p. 201). Glaser argued that these stages should occur naturalistically, with the theory being grounded in the data rather than procedures, highlighting that he saw deductive logic in data collection as a threat to theoretical sensitivity (Glaser, 1992). Glaser accused Strauss and Corbin of presenting an entirely different method. He described their techniques as *'fractured, detailed, cumbersome and over-self-conscious'* (Glaser, 1992, p60), arguing that they interfered with rather than facilitated the key process of discovery. Yet Strauss and Corbin maintained that their guidance was vital for the value of Grounded Theory to be realized (McCrae & Purssell, 2016). Grounded Theory became differentiated as 'classic' or 'Straussian' with the latter proving popular within nursing research (McCrae & Purcell, 2016).

Strauss died in 1996 and Corbin went on to modify the approach in a third edition

of their collaboration (Corbin & Strauss, 2008), supporting further departures from the original text, and explicitly embracing the qualitative paradigm, including an acknowledgement of the position of the researcher and the impact and involvement of the researcher within a study. Kathy Charmaz, a student in a doctoral programme led by Strauss, where she had been taught Grounded Theory by Glaser, then developed a further approach. Charmaz criticized classic Grounded Theory as naïve empiricism, whereby a supposedly neutral observer seeks external truth (McCrae & Purssell, 2016). Whilst Charmaz acknowledged the importance of the work done by Glaser and Strauss, and honoured them as pioneers, she attributed their stance to the positivism of their time of writing (Charmaz, 2008). Charmaz recognised that Strauss and Corbin regarded reality as a product of interpretation, but argued that their manualised technique reinforced objectivism with its coding framework and verification (Charmaz, 2008). Charmaz set out to revitalize Grounded Theory as a constructivist method, emphasizing reflexivity and shared realities (Charmaz, 2006).

The following table (Table 11) outlines the history and key stages for the development of Grounded Theory and the variations within that:

Table 11 – History and key stages of Grounded Theory:

Key Text	Development of Grounded Theory
Awareness of Dying Study Glaser & Strauss (1965)	This provided the immediate context for the creation of Grounded Theory
The Discovery of Grounded Theory, Glaser & Strauss (1967)	This text defined and demarcated the rigorous methodology and provided a Grounded Theory handbook for researchers.
Time for Dying, Glaser & Strauss (1968)	Key study focusing on the original Grounded Theory methodology proposed by Glaser and Strauss.
Status Passage, Glaser & Strauss (1971)	Key study focusing on the original Grounded Theory methodology proposed by Glaser and Strauss.
Basics of Qualitative Research: Grounded Theory Procedures and Techniques, Strauss & Corbin (1990, 1998)	Strauss and Corbin incorporated some deductive analysis and acknowledged the role of existing theories in sensitizing grounded theory researchers. They described this as a natural evolutionary process (Strauss & Corbin, 1990)
Emergence vs. Forcing: Basics of Grounded Theory Analysis, Glaser (1992)	Glaser felt that Strauss and Corbin's book presented a version of Grounded Theory that was too prescriptive.
Situational Analysis: Grounded Theory After the Postmodern Turn, Clarke (2005)	Presented as an extension to Strauss's framework, by utilizing established coding and memoing strategies. It also introduces three kinds of maps, situational, social and positional in order to extend the Grounded Theory method.
Constructing Grounded Theory, Charmaz (2006, 2014)	The focus is placed on the construction of theory rather than its discovery.

3.11 - Constructivist Grounded Theory

Charmaz (2006) developed a constructivist version of Grounded Theory, proposing that theories are not discovered but rather we construct them through *'past and present involvements and interactions with people, perspectives and research practices'* (p 10). Charmaz (2006) stated that constructivist Grounded Theory lies within the interpretive approach. It utilises flexible guidelines, has a theory that *'depends on the researcher's view and learning about the experience within embedded, hidden networks, situations, and relationships, and makes visible hierarchies of power, communication and opportunity'* (Cresswell, 2013, p87). Glaser (2002) described Charmaz's reconstruction as a "misnomer" (p 1), and rejected many of the principles of the constructivist paradigm, particularly its focus on descriptive capture, and the tendency to describe the data and emerging categories, rather than taking an analytical approach. Glaser (2002) stated this is contrary to the goal of conceptualization within Grounded Theory, asserting that Charmaz's reworking lacks the properties of *'abstraction, conceptualization and systematic theory generation inherent within 'pure' Grounded Theory'* (p13). In contrast, Bryant (2003) supported Charmaz's position stating that a researcher employing Grounded Theory as their method cannot be rendered an impartial observer as they inevitably have influence over their analysis, reinforcing that a theory is actively constructed rather than neutrally discovered.

Whilst retaining aspects of Glaser and Strauss' original Grounded Theory method, Charmaz (2006) proposed they should be used flexibly in order to recognise the role of the researcher and the ways in which theories are developed within the context of social and power relations. A number of characteristics can facilitate this theory development, with an important element being constant comparison (Glaser & Strauss, 1967; Charmaz, 2006), a key component of both traditional and constructivist Grounded Theory. Charmaz (2006) defines this method as the process of continually sifting and comparing data in order to explore similarities or differences. Charmaz (2006) expands on this when looking at interview data, by identifying that this may involve comparing statements within and across interviews to create theoretical codes or categories. The aim of the coding process is to develop the emerging theory through

increasing levels of abstraction in order to arrive at a core category, which may account for all of the collected data (Dey, 2004). It is therefore expected that a 'saturation point' will be reached, with new data no longer appearing to add any new meaning to the proposed theory (Rennie, 1998; Charmaz, 2006).

Glaser and Strauss (1967) advised simultaneous involvement in data collection and analysis in order to use early theory development to help shape subsequent data collection. Charmaz (2006) discussed the expectation that analysis begins as soon as the first piece of data is collected, to enable emerging themes and gaps in theory to be further investigated in later interviews. This process facilitates theoretical sampling (Charmaz, 2006), which involves the targeted sampling of events, people, or documents, to refine ideas as the research progresses (Glaser & Strauss, 1967). Therefore the researcher may seek a particular person to interview or revise the questions being asked in order to elaborate the emerging theory (Charmaz, 2006).

Although not unique to Charmaz's approach, another important feature of Grounded Theory is theoretical sensitivity, which expresses the researcher's ability to respond to the subtle nuances and meanings within the data (Strauss & Corbin, 1998). Charmaz (2014) defines it as '*the ability to understand and define phenomena in abstract terms and to demonstrate abstract relationships between studied phenomena*' (p161). This is achieved by moving through the data analysis and by continually making comparisons, following leads and establishing connections (Charmaz, 2006). Memo writing is also noted as an important feature of Grounded Theory (Charmaz 2014), with memos being generated in parallel to the coding process and assisting the researcher in category development. This is thought to provide a secure base for reporting on the research (Corbin & Strauss, 1990), suggesting the identification of researcher position within the research process and establishing core ideas and concepts as they emerge in the data.

Creswell (2007) identifies the aim of Grounded Theory as being to extrapolate a single category from the coding list as the central phenomenon of interest. Charmaz (2006) focuses on the idea of constructing an original theory rather than

necessarily a single category. This appears to take the notion of multiple realities into consideration and the acknowledgement that data is co-constructed by the researcher and the participants.

In order that the researcher remains closely aligned to the constructivist Grounded Theory method throughout the course of the research study a number of steps and actions are recommended (Charmaz, 2014, p15):

- 1. Conduct data collection and analysis simultaneously in an iterative process*
- 2. Analyze actions and processes rather than themes and structure*
- 3. Use comparative methods*
- 4. Draw on data (e.g. narratives and descriptions) in service of developing new conceptual categories*
- 5. Develop inductive abstract analytic categories through systematic data analysis*
- 6. Emphasise theory construction rather than description or application of current theories*
- 7. Engage in theoretical sampling*
- 8. Search for variation in the studied categories or process*
- 9. Pursue developing a category rather than covering a specific empirical topic*

Charmaz (2014) argues that most researchers engage in actions one to five but do not make the remaining actions evident.

3.12 – Philosophical Roots of Grounded Theory: Pragmatism & Symbolic Interactionism

Grounded Theory has links with Symbolic Interactionism and Pragmatism. The term pragmatism, derived from the Greek work for ‘action’ (Barnhart, 1995), is a means of determining the value of an idea by its outcome in practice and conduct (James, 1998). Schwandt (2001) identifies two defining features of pragmatism: anti-foundationalism, meaning that knowledge may not be completely known in an objective positivist way, and the fallibilistic view that

our knowledge of the world may be limited and thus may not be fully known. The importance of Pragmatism for Grounded Theory methodology was noted as a key early influence (Bryant, 2009). Pragmatism had an influence on Charmaz's perspective that knowledge is socially constructed and we cannot know things completely, only partially (Charmaz, 2014). Shalini (1991) notes Pragmatism as a humanistic movement in philosophy, incorporating the idea and role of humans in the creation of objective and meaningful reality.

Pragmatism is considered a precursor of Symbolic Interactionism (Plummer, 1996). Charmaz (2014) defined Symbolic Interactionism as '*a dynamic theoretical perspective that views human actions as constructing self, situation, and society*' (p262). It originated in work by George Herbert Mead and fellow 'Chicago School' sociologists (Blumer, 1969), who identified that society functions as a dynamic process of interpretation, thus individual perspectives are vital to theoretical understanding. Blumer (1969) states that there are three key tenets to Symbolic Interactionism:

- 'The first premise is: human beings act toward things on the basis of the meanings that the things have for them.

-The second premise is: the meaning of such things is derived from, or arises out of, the social interaction that one has with ones fellows.

-The third premise is: these meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters' (p2)

The current research study aimed to find meanings in context and how participants made meanings from events, how they acted and importantly interacted (Blumer, 1969). I had to develop '*a familiarity with what is actually going on in the sphere of life under study*' and in doing so '*be able to lift the veil that obscures or hides what is going on*' (Blumer, 1969, p39). For this study, interviewing as a method of data collection was a suitable way for capturing meaning and experience and thus '*lifting the veil*'. Charmaz (2014) noted that

Symbolic Interactionism and Grounded Theory methods fit, complement and advance each other, with Grounded Theory retaining certain elements from Symbolic Interactionism. Charmaz (2014) states that Symbolic Interactionism *'assumes that individuals are active, creative, and reflective and that social life consists of processes'* (p345), linking back to Grounded Theory's focus on social processes and social interactions.

Constructivist Grounded Theory asserts that meaning, rather than being discovered, is constructed through symbolic interaction between persons, objects and culture, and that multiple, rather than single interpretations and meanings arise out of these interactions (Crotty, 2003). In line with the constructivist approach, Symbolic Interactionism shares the assumption that multiple realities exist (Blumer, 1969). Symbolic Interactionism therefore acts as a background guide within this study, that is helping to direct me as a researcher about where to look to make sense of the collected data and to gain an understanding of what is being heard within the interview process (Stern & Porr, 2011).

3.13 – Summary

A social constructivist approach was adopted for this study due to the fit with the research questions and the position I take as a researcher and a nurse. The research questions are explorative and I sought to understand participants' own experiences in order to develop a theory or pattern of meaning related to self-care and self-compassion in nursing. The positivist and post positivist approaches were considered unsuitable for this particular field of interest as previously discussed. In relation to a positivist approach the researcher is viewed as separate from the research, and as a nurse within the NHS it would be difficult to completely detach from the participants. Given that I wished to understand what is happening for nurses within their clinical environments and within their 'realities', to detach from this would be difficult. The participants' thoughts and ideas are likely shaped by their surroundings, inclusive of emotional, cultural and social factors. Therefore, there is a need to access and explore how they construct their own reality, and to accept that for participants multiple realities may exist. Hence the use of a constructivist approach. Part two of this chapter explores the research methods employed to conduct the study.

Part Two:

Research Methods

3.14 – Overview

This section presents an overview of the methods employed in accordance with the constructivist approach to Grounded Theory (Charmaz, 2014). The research design and set-up, population studied and the means of gathering data are discussed. The process of data analysis is described and the principles of ethics applied to the study are outlined. The processes and procedures taken to ensure rigour and trustworthiness of the study results are then set out.

3.15– Research Questions

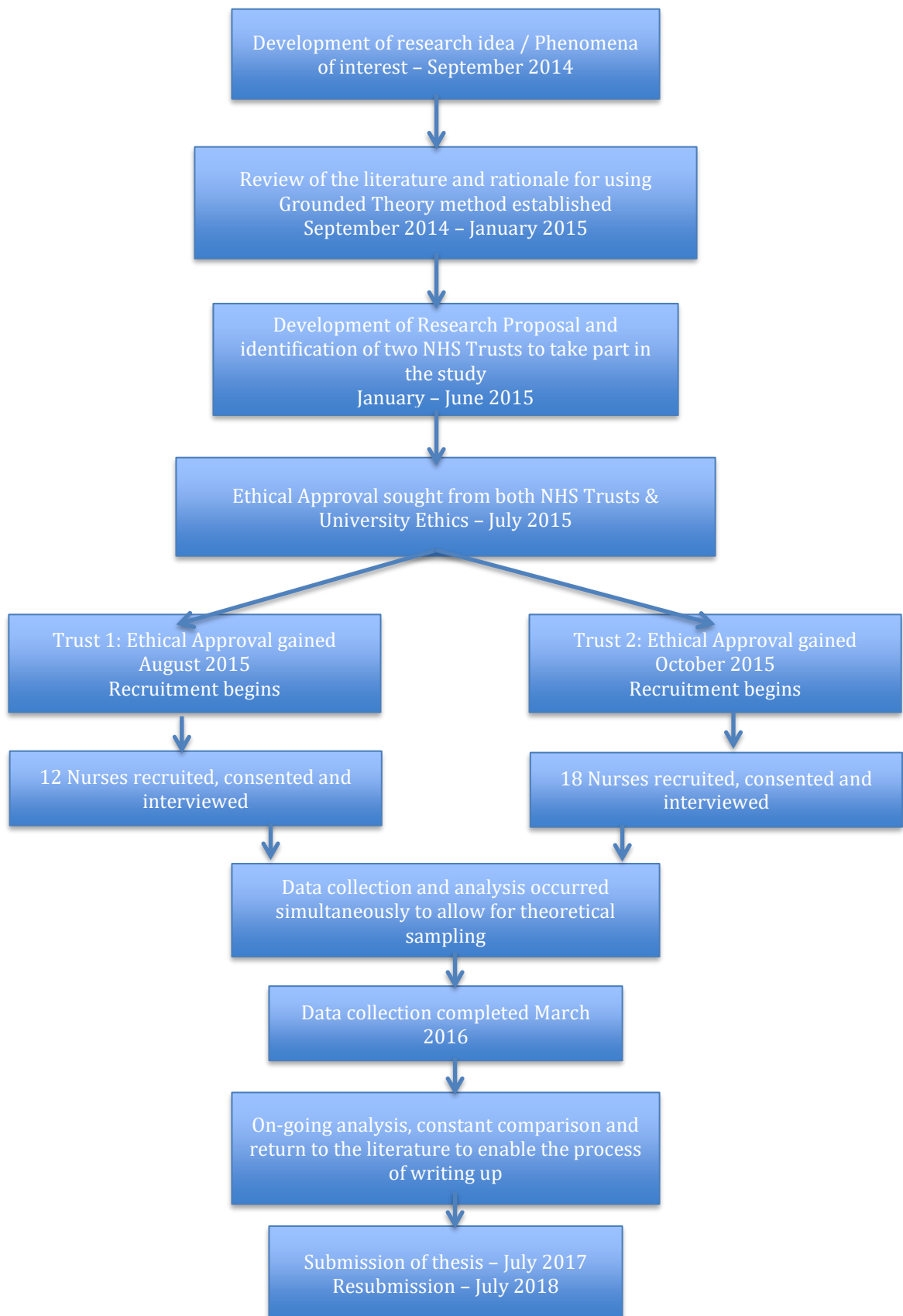
Throughout the research and this thesis the two following questions were held in mind to guide the study:

- What are nurses' experiences of self-care and self-compassion?
- How do these experiences relate to compassionate care giving?

3.16 – Research Process:

The flowchart represented in Figure 1 shows the research process and structure for this study, from study inception to conclusion.

Figure 1: The Research Process



3.17 - Sampling and Recruitment

Qualitative researchers often sample for meaning (Luborsky & Rubinstein, 1995) by recruiting individuals who can provide verbal description and narratives related to the experience of interest. Given the research focus, the gaps in knowledge identified in Chapter 2 and the questions guiding the study the sample comprised of registered nurses and nurse managers. Inclusion criteria were English speaking, first level registered nurses across the following nursing specialties: Adult, Mental Health, Child and Young People, and Learning Disabilities. Exclusion criteria for the purpose of this study included other healthcare disciplines and healthcare assistants. See table 12 for the sampling variables employed for this study.

Table 12: Sampling Variables

Variables sought during initial recruitment	Recruitment
Registered Nurses	53 nurses expressed an interest and 30 nurses participated.
Nurses working within the NHS	Two NHS trusts were approached and agreed to take part.
Nurses from across the nursing disciplines	The sample comprised of RGN's, RMN's and RNLD's. There were also two nurses who held dual qualifications. Unfortunately no RNC's were recruited despite attempts made.
Nurses from a variety of settings and specialisms	Nurses were recruited from both inpatient and community settings and across the specialisms.
Nurses from different bandings	Nurses from band 5 to band 8b took part through the initial sampling and theoretical sampling process.

It was anticipated that the findings would have a wider relevance if data were collected from more than one clinical setting and spanning a variety of nursing specialties (Williams, 2002). Therefore, two NHS Trusts were included within

the study. A total of 53 nurses expressed an interest; 30 were recruited, consented and interviewed. The remaining 23 did not respond to further correspondence or found it difficult to arrange a time to meet. Data collection ceased after 30 nurses were interviewed as data saturation was reached (discussed below). Unfortunately, no nurses from the Children and Young People branch of nursing were recruited, with this being further discussed in Chapter 5.

Participants were recruited initially by sending a recruitment poster via email to the research departments situated in both NHS trusts involved in the study, and to nurse leaders (See appendix 3 to view the recruitment poster). When nurses expressed an interest, they were sent the participant information sheet and consent form (see appendix 4). Purposive sampling was employed in this initial stage of recruitment, a method by which participants are chosen based on the qualities and variables they possess (Etikan et al, 2016). The researcher sets out to find people who can shed light on the topic of interest through knowledge or experience (Bernard, 2002). The literature review highlighted a lack of research involving nurses, within the field of interest, which led me to recruit across the nursing disciplines and specialties. This need to recruit across the field of nursing was reinforced by previous researchers who attempted to sample specific nursing groups i.e. emergency nurses (Hooper et al, 2010) and went on to conclude that all nurses were at risk of compassion fatigue regardless of discipline and specialism. Experience in the role was also identified within the literature review as potentially influencing nurses' response to the emotional demands of the job. Therefore, variation in terms of seniority was sought when initially recruiting. Purposive sampling allowed for the generation of '*a rich set of materials*' from which to begin the analysis (Pidgeon & Henwood, 1996, p89).

A combination of purposive followed by theoretical sampling is suggested by Charmaz (2014), with McCrae and Purssell (2016) supporting this and stating '*a sequential approach of purposive and theoretical sampling may be appropriate if the former is used to seed the latter*' (p2290). Hence, as the study progressed, theoretical sampling ensued, with participants asked to identify suitable colleagues who could facilitate the lines of enquiry being followed to enrich the emerging theory. For example, it became apparent from the data that it would be

useful to sample nurse leaders and newly qualified nurses to expand some of the emerging categories and to follow-up leads within the data (Charmaz, 2014). This allowed for an in-depth exploration of the experiences of nurse leaders in relation to the impact of leadership on self-care and self-compassion, and to establish how newly qualified nurses felt coming into the current healthcare system and the early key messages they received about caring for themselves. Reviewing the literature supported this as it suggested that nursing students and newly qualified nurses were particularly prone to things like burnout.

Data were simultaneously collected and analysed until data ‘saturation’ was reached (Charmaz, 2006). Charmaz (2006) recommends including 20-30 individuals to develop a well saturated theory. In this study data saturation appeared to have been reached once 30 individuals had been interviewed. Saturation was assessed based on no new data emerging, and having categories that were sufficiently dense. However, the point of saturation within studies is an area of contention, with disagreements about its meaning often arising in the literature. Bryman (2012) points out that you cannot anticipate what kind of sample size will be needed to achieve saturation and it is often left to outside variables such as funding, timescale and recruitment. Wiener (2007) agrees with these points and also states that saturation is a judgment, which makes it difficult to verify. Morse (2011) identifies that researchers often proclaim saturation rather than prove it has been achieved, and states that researchers need to be self-critical about saturation. In this study I used the process of supervision alongside data analysis in order to judge the point where saturation was reached. Dey (1999) states that the term ‘saturation’ is imprecise. He argues instead that the term ‘theoretical sufficiency’ better fits how researchers conduct Grounded Theory, meaning categories are sufficiently populated, as was the case with this study. This was assessed by the amount and depth of data within each category, with lines of inquiry having been followed, through theoretical sampling and constant comparison, and through supervisory discussion and reflection. Dey (1999) also identifies that the process of ‘theoretical sufficiency’ helps to resolve personal concerns that whenever data collection has ceased there may always be another participant with new ideas somewhere. For the purpose of this study, recruitment was easier and quicker than anticipated and therefore time was not a

factor in reaching theoretical saturation, but rather the judgment that there was an absence of new information emerging from the data, categories were dense and with this being checked and discussed with the supervisory team. See tables 13 and 14 for participant demographics and characteristics of those individuals recruited.

Table 13: Participant Demographics

	NHS Trust 1	NHS Trust 2
Mean years experience	23.5 years (7yrs – 40yrs)	19 years (1yr – 33yrs)
Male	1	5
Female	11	13
RGN	12	3
RMN	0	12
RNMH	0	1
Dual Qualified (DQ)	0	2
Band 5	1	3
Band 6	6	6
Band 7	4	7
Band 8a	1	1
Band 8b	0	1

Table 14: Participant Characteristics

Participant Discipline and Number	Years qualified	Role	Band	Length of interview
RGN1	11	Non-Clinical Role	Band 6	1h01m51s
RGN2	29	Senior Clinical Role	Band 8a	45m54s
RGN3	39	Non-clinical role	Band 7	44m55s
RGN4	36	Clinical Role	Band 6	1h17m14s
RGN5	9	Clinical Role (Trained outside of UK)	Band 6	38m57s
RGN6	32	Clinical Role	Band 6	27m47s
RGN7	29	Clinical Role	Band 6	35m35s
RGN8	12	Clinical Role	Band 6	31m26s
RGN9	17	Clinical Role (Trained outside of UK)	Band 5	35m26s
RGN10	40	Senior Clinical Role	Band 7	1h 21m18s
RGN11	11	Senior Clinical Role	Band 7	36m50s
RGN12	30	Senior Clinical Role	Band 8b	1h07m12s
RGN13	7	Senior Clinical Role	Band 7	41m41s
RGN14	29	Senior Clinical Role	Band 8a	44m38s
RMN1	3	Community Clinical Role	Band 6	1h06m29s
RMN2	1	Community Clinical Role	Band 5	26m43s
RMN3	6	Community Clinical Role	Band 6	57m53s
RMN4	5	Clinical Role	Band 6	58m03s
RMN5	31	Senior Clinical Role	Band 7	1h06m02s
RMN6	28	Senior Clinical Role	Band 7	1h03m07s
RMN7	4	Community Clinical Role	Band 5	41m28s
RMN8	8	Community Clinical Role	Band 6	38m45s
RMN9	15	Community Clinical Role	Band 5	26m40s
RMN10	28	Community Clinical Role	Band 6	47m17s
RMN11	19	Senior Clinical Role	Band 7	54m57s
RMN12	31	Senior Clinical Role	Band 7	1h31m54s
RMN13	16	Senior Clinical Role	Band 7	44m09s
RNMH	7	Community Clinical Role	Band 6	55m02s
DQ1	33	Senior Clinical Role	Band 7	56m56s
DQ2	31	Senior Clinical Role	Band 7	59m12s

The tables above provide an overview of the demographics and characteristics of the nurses recruited into the study, their discipline, and years of experience, gender and Agenda for Change banding. I have grouped according to discipline, and included brief role rather than specialty to ensure anonymity is maintained (Morse & Coulehan, 2015).

3.18 – Description of study sites

NHS Trust One:

This Trust is one of the UK's largest teaching trusts responsible for managing two large hospitals. The hospitals between them serve a population of over a million people. The organisation employs more than 8000 staff.

NHS Trust Two:

This trust provides a wide range of services to a population of approximately one million people including inpatient, community and day clinics across mental health, learning disabilities and community physical health services. The organisation provides services from over sixty locations and employs more than 4000 staff.

3.19 – Interview Procedure

Creswell and Brown (1992) state that interviews play a central role during data collection in a Grounded Theory study. Interviews took place at a participant's home, at the University or in a quiet room within a clinical environment. Informed consent was sought and recorded prior to the interview, allowing each participant time to discuss any concerns or to ask any questions. Interviews were recorded on a digital voice recorder, so I could concentrate on what the participant was saying rather than making ongoing, detailed notes (Barker et al, 2002; Smith, 1995). Charmaz (2006) suggests that digitally recording and transcribing data is useful to enhance the quality of findings. Silverman (2006) expands on this point by stating that inclusion of subtle nuances such as pauses, emphases and context to quotations are important. I set some time aside following each interview to record any initial observations, impressions and thoughts in a reflexive journal, as is recognised within the constructivist approach (Charmaz, 2006).

An interview guide was formulated (see appendix 5 for a copy of the initial interview guide and the subsequent revised list of additional lines of enquiry followed) based on ideas generated from the literature review, supervisory discussion and reflexivity. It was used flexibly. This was to ensure that I asked

questions from the guide but was also directed by participants and issues and ideas that seemed most relevant to them at that time and in that context. Charmaz (2006) states that the interview guide can be revised between interviews, according to the principles of theoretical sampling, and following leads within the data. Stern and Porr (2011) highlight that such a guide is only required in early interviews, after which the researcher follows up on leads, theoretically sampling data to fill out early codes and categories. I found during the interviews that certain topics needed further exploration with questioning becoming more specific over time. However, leading questions were avoided, to ensure that participants were free to give their own interpretation of the issues being discussed. For example, the issue of nursing identity arose among a number of participants and it was felt an additional question should be asked to explore this early category. A leading question might be: 'Do you consider that nursing is a key part of your identity and sense of self?' This may have caused the participant to answer in a way that met my line of thinking rather than leaving them to explore an idea, and talk about their experience. Therefore, I asked: 'What does nursing identity mean to you?' This left the participant to talk about what nursing means to them. The interview guide became more focused as theoretical sampling ensued, particularly when identifying nurse leaders and nurses who had just qualified. Questions were included at this point to look at the role of the leader in giving permission to their staff in order to be self-caring and for newly qualified nurses to focus on their position with the current NHS and coming into a challenging culture. A question was also added to look at motivations to become a nurse, as this appeared important during early interviews.

A key aspect to the interviews was the understanding that participants felt able to provide accounts of a reality as perceived by them and through dialogue with the interviewer (Charmaz, 2014). By talking with participants, the researcher can learn about what happens, attempts to discover hidden assumptions, what these mean for participants and how they make sense of their own world (Charmaz, 2014). I was able to question participants about their own experiences and viewpoints, including using para-phrasing and summarising techniques throughout in order to check my understanding of what had been said. These techniques were also used in order to prompt participants to expand their

responses at times.

3.20 – Data Management

Charmaz (2006) proposes that researchers should always transcribe their own data to become immersed within it. All interviews were transcribed by myself, with any identifiable information being altered or removed in the transcripts. Recordings were transcribed word for word to preserve natural language. As I listened to each recording I made notes and reflections and ensured I fully listened to what was being said. Each transcript was sent back to the participant to check the information and to give them the opportunity to have data removed if required due to the emotive nature of some of the discussion. Other than data that may identify participants, no other data were removed and all participants were happy with their transcripts. Each transcript was stored within NVIVO, which supported data analysis.

There are many approaches to analysis of qualitative data (Dey, 1993; Silverman, 1993; Miles & Huberman, 1994; Coffey & Atkinson, 1996; Cresswell, 1998). All suggest ways of making sense of data, taking aspects including language, structure and meaning into account. However, before and during analysis there is a need to organize the data (Miller, 2000). The steps to this are often achieved through the process of closely aligning yourself to a particular methodological approach, such as Constructivist Grounded Theory (Charmaz, 2014) as used within this study. NVIVO was used following coding on paper in an attempt to manage the vast array of collected data, initial codes, focused codes and emerging theory. NVIVO was also used as an audit trail and to add rigour to the analysis process. Whilst Smith and Hesse-Biber (1996) identify NVIVO is used mainly as an organisational tool, it has other benefits. Bazely (2007) notes five tasks that NVIVO can assist with during the qualitative research process: Managing data; Managing ideas; Asking queries of the data; Modelling visually and Reporting. These tasks, together, aid in the development of concepts, categories and emerging theories (Hilal & Alabri, 2013). Within my study NVIVO was helped with managing and organising the data, and the query function was used to explore and view the coded data. Visual modeling and reporting through summarising were briefly looked at within NVIVO, but the

paper and written method were preferred.

Welsh (2002) proposes that researchers should recognise the value manual and electronic tools in qualitative data analysis and management, and rather than favouring one above the other, make use of both and see the advantages of the two methods combined, which can make the researcher more confident in the interpretation of data due to the feeling that they are being rigorous and transparent. Rigour and transparency are achieved through ensuring each stage of the analysis are completed and a clear audit trail exists (Kelle & Laurie, 1995). For this study, analysis was completed on paper initially, before then moving to NVIVO to aid in both the organisation and management of the data. NVIVO enabled me to move easily amongst the data, facilitating the examination of leads and expanding of categories. For example, NVIVO facilitated the process of exploring frequency, so I was immediately able to see how frequently a particular theme or code occurred and in what section of a transcript. Whilst Grounded Theory is not primarily concerned with frequency, the ability to do this allowed the sifting, moving between transcripts and sections of data, and made the interpretation of the data more manageable. The use of both manual and electronic coding enabled me to stay closely aligned to the participants' words, to engage in constant comparison, to look for connections and to move into theorising of the data.

3.21 – Data Analysis

It is important to show the process of moving from the raw data to the final core themes during the process of data analysis. I remained closely aligned to the process set out within Constructivist Grounded Theory (Charmaz, 2006; 2014) and in this section describe each phase of analysis.

3.21.1 – Initial Coding

Initial coding was employed in order to become familiar with the data and to identify emerging themes. This entailed line-by-line coding to carefully examine the data and to become aware of potential categories and processes (Charmaz, 2006). Through the process of line-by-line coding I gained an insight regarding what kind of data to next collect. During this process 'In Vivo' codes were

utilised, to preserve participants' meanings of their views and actions (Charmaz, 2006). In Vivo codes can be defined as exact words or phrases used by the participants (Crabtree & Miller, 1992). Charmaz (2006) suggests asking the question 'what is happening?' when coding. She also discusses the use of gerunds to look at elements such as: doing, asking, feeling, disagreeing, suffering, judging and justifying. Gerunds enable the analysis of actions and processes, rather than themes and structure. I attempted to use gerunds throughout the coding process to make the data and the emergence of codes and categories more active. Examples of initial codes are presented in table 15 (Further initial codes can be viewed in appendix 6):

Table 15: Example of initial coding

Initial Coding	Interview Excerpt from Participant 1
<ul style="list-style-type: none"> -Sitting within nurse training -Deciding how best to care for the patient? -Prioritising the patient -Finding an absence of self-care within care training -Needing an awareness of self-care -A dearth of information being available -Significant physical aspects of nursing -Emotional impact of nursing -Needing a certain character to be a nurse? -Requiring certain innate qualities -Not being an easy job -Having the capability of providing good care -Being one of many who is unable to do this -Failing to address own needs -Concept at the forefront of the mind -Being motivated to engage ‘what am I going to do about this?’ -Helping the self -Getting lost amongst competing demands for attention -Being unable to consider the self 	<p>It's, in training, your focus rightly so erm is obviously how best to care for your patient (yeah) and that's, that's good (laughs), but there is nothing in the training programme about making me aware of self care, there was nothing, erm and I think that when you, you know you look at the physical aspect of the job of which is quite significant, the emotional impact of our job is significant erm and don't get me wrong I know that not everybody can be a nurse, you know, it has you know, its not an easy job (no), but I think, that those of us who are capable of providing you know very good care, I think that erm, I don't know I just think, that if I'm not aware of it, I'm one of many, do you know what I mean (yeah) and I just think that the impact of not being aware you know of, of you know as a concept you know at the forefront of your mind then you're not as likely to think you know ok so what am I going to do about this? Or you know what could I do to, to help myself, its not in your mind, in the forefront of your mind, just literally you're focusing on all your other jobs you're going to have to do in life, and you don't even consider yourself, its as simple as that.</p>

3.21.2 – Focused Coding

Following initial coding, focused coding was employed. Charmaz (2006) states that focused coding is a means of using the most significant or frequent codes to sift through and explain large amounts of data. Charmaz (2014, p140-141) proposes the following list to aid in defining which codes are best placed to become focused codes:

- *What do you find when you compare your initial codes with the data?*
- *In which ways might your initial codes reveal patterns?*
- *Which of these codes best account for the data?*
- *Have you raised these codes to focused codes?*
- *What do your comparisons between codes indicate?*
- *Do your focused codes reveal gaps in the data?*

Below, in table 16, is an example of focused coding within this study (the process of focused coding and early category generation can also be viewed in appendix 7):

Table 16: Example of focused coding

Focused Coding	Interview excerpt from participant 6
-Identity versus role -Becoming good at closing off -Dealing with difficult emotions -‘Opening the gates’ – Overwhelming impact	I don’t know really, is there a link yeah I think so, I think there is a link, because you (pause), whether that’s part of your make-up anyway and that’s the way you are, or whether it develops more over time with doing the job that we do, I think but I think we become very good at closing off and not actually dealing with things because it’s far easier, yeah, yeah and I think that’s just not for nurses but for doctors as well, I think for anybody, anybody in a profession where you deal with things that are really unpleasant at times and whether that’s us, the police force, you know the ambulance, you know you learn you actually as a almost as a self-preservation you know, you close, you shut things off and I think that, that does at times then sort of transmit into your personal life as well, and that you actually will do that there as well (ok). Yeah, because to actually then open the gates, you’re opening it all the way along.

3.21.3 – Theoretical Coding

In the final stage of analysis, the relationships between focused codes were more fully explained and theoretical categories developed, in order to advance towards an emerging theory (examples can be viewed in appendix 8). Memo writing was utilised throughout to help with this process (see below for further details), by focusing on any coding changes or modifications, any explanations, reflections, ideas for theoretical sampling or any links to the existing literature (Pidgeon &

Henwood, 1996). Charmaz (2014) states that theoretical codes are used in order to help theorize the data and focused codes help to tell a coherent, analytical story. Within this study theoretical coding helped to clarify and sharpen my analysis, enabling me to move from the initial coding process through to the final core process and the conceptual framework, which is presented in chapter 4.

3.21.4 – Theory Development

Birks and Mills (2011) identify the goal of Grounded Theory is to develop an *‘explanatory scheme comprising a set of concepts related to each other through logical patterns of connectivity’* (p113). For this study the aim was to further understand the field of interest by the process of conceptualising and theorising. Charmaz (2014) states *‘theorizing foster seeing possibilities, establishing connections and asking questions’* (p244). Through use of manual and electronic data analysis I was able to stay closely aligned with the process outlined by Charmaz (2014) in order to work through the stages of early coding and analysis to the later stages of conceptualizing and theorising. The core category ‘Needing Permission’ emerged as central, it linked and related to other connections and leads within the other codes and categories, and was frequently within the data (see appendix 9). Charmaz (2014) states *‘for constructivists, theoretical concepts serve as interpretive frames and offer an abstract understanding of relationships’* (p248). It is important to note, that despite following a specific methodology driven process, this is my interpretation of the data, and is therefore specific to time, context and researcher position as will be further explored in Chapter 5.

3.22 - The Constant Comparative Method

The constant comparative method is an analytic tool within Grounded Theory that promotes reflective thinking (Dunne, 2011; Giles et al, 2013). It involves constantly comparing data, codes, categories and memos (Charmaz, 2014), and can also be used to integrate and return to the literature. Conrad et al (1993) define the process as: *‘combining systematic data collection, coding, and analysis with theoretical sampling in order to generate theory that is integrated, close to the data, and expressed in a form clear enough for further testing’* (p. 280). In Grounded Theory, constant comparison is ongoing, as it is the process by which researchers sort the emerging themes on account of their similarities

and differences (Goulding, 1999).

Constant comparison was applied as an ongoing process within this study, comparing and contrasting concepts relevant to the phenomena of self-care, self-compassion and compassionate care giving. For example, within this study I coded 'conscious' examples of self-care and self-compassion, whereby participants acknowledged acts in which they cared for themselves, with 'unconscious' acts, whereby participants were self-caring in subtler, often unacknowledged or unrecognised ways. I then reviewed the data in order to look for examples of participants who were able to self-care and those who were not, to identify key characteristics, enablers and barriers. This ensured a focus to the data analysis and that the categories were sufficiently saturated. Constant comparison enabled the process of comparing and contrasting categories. Memos were also regularly written and compared alongside the data.

3.23 - Memo Writing

The act of writing memos was used as a key tool for the exploration and development of codes at every stage of the analysis process. Pidgeon and Henwood (1996) identify that memos may include explanations of or modifications to codes, categories, general theoretical reflections, ideas for theoretical sampling, or links to the literature. Elliott and Lazenbatt (2005) depict memoing as an essential element of the Grounded Theory methodology to control distortion during analysis by sensitizing researchers to their personal biases. This fits with the idea of the co-construction of data, acknowledging the researcher is part of the research process. Charmaz (2014, p171) identifies the following as ways to generate memos:

- Define each code or category by its analytic properties*
- Spell out and detail processes subsumed by the codes or categories*
- Make comparisons between data and data, data and codes, codes and codes, codes and categories, categories and categories*
- Bring raw data into the memo*
- Provide sufficient empirical evidence to support your definitions of the*

category and analytic claims about it

-Other conjectures to check in the field setting(s)

-Sort and order codes and categories

-Identify gaps in the analysis

-Interrogate a code or category by asking questions of it

I found memo writing to be a vital part of the research process as it allowed me to engage with the data, identify gaps in the analysis, look at relationships within the data and helped shape and determine theoretical sampling. The memos were also a means of exploring processes associated with the study's execution, for example relating to participant recruitment. Furthermore, they supported the analysis and interpretation of data. An example of a memo can be found in Appendix 10. In addition, some memos are presented within the findings chapter.

3.24 - Clustering and diagramming

Charmaz (2014) defines clustering as a shorthand prewriting technique for getting started with organising data. It is used to create a map of work and to creatively look at relationships, key components of the data collected and how these may fit together and relate to other phenomena (Clarke, 2003). Charmaz (2014, p 185) identifies clustering and the use of diagrams as particularly useful in order to gain control of certain elements of the data. She defines the following steps as key:

-Start with the main topic or idea at the center

-Work quickly

-Move out from the nucleus into smaller subclusters

-Keep all related material in the same subcluster

-Make the connections clear between each idea, code, and / or category

-Keep branching out until you have exhausted your knowledge

-Try several different clusters on the same topic

-Use clustering to play with your material

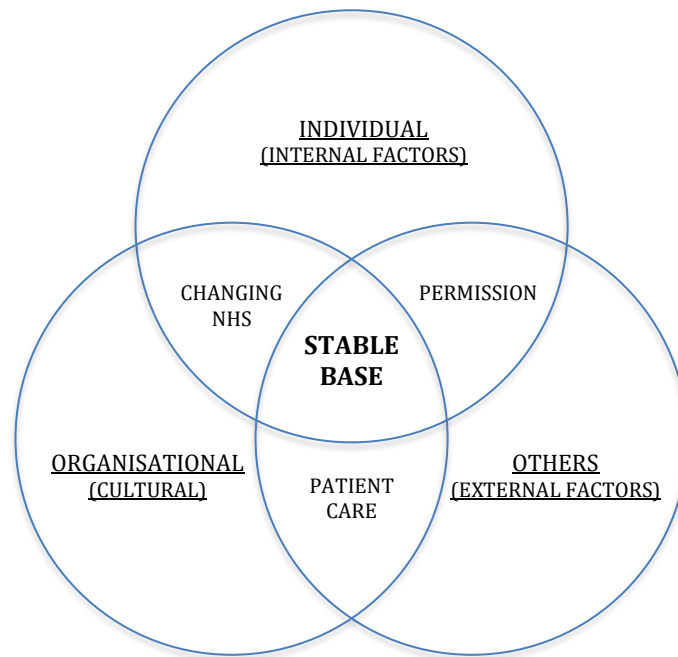
Due to the amount of data collected, clustering and diagramming proved particularly useful in gaining a sense of control from the start of the analysis process and to begin to look at early relationships within the data. It also helped to shape the findings presented in Chapter 4. Early maps and clustering of the key concepts being explored within this study can be seen in appendix 11. The following is an example of a later diagram used to help make sense of relationships and lines of enquiry within the data:

Figure 2: Diagram 1 - Example of a linear depiction of category relationships



This was a very linear diagram and whilst helping to make sense of a possible relationship between emerging categories, I felt was too simplistic and not accurately reflecting how these categories were related. The following is a slightly later diagram, which shows a move in thinking, and I feel it more accurately reflects how the categories may interconnect:

Figure 3: Diagram 2 – Example of interconnecting categories



As can be seen above, initially the core idea centred on a stable base. However, despite this remaining an important component to my findings, permission later emerged as more central. This shows that during the process of data analysis there may be a number of false starts or changing theoretical constructions. These refinements in thinking during analysis occur through ongoing immersion in the data, constant comparison and theoretical sampling.

3.25 - Reflexivity

During data collection I reflected on my own experience as a nurse for the past 19 years, and the influence of this on the line of questioning and interpretation of the data. These issues were continuously reflected upon through use of a reflexive journal to ensure self-awareness of my own experiences, assumptions, perceptions, core values, feelings and beliefs. Supervision was also utilised throughout the research process on a monthly basis allowing for a continuous dialogue and reflection. This allowed me to discuss my views and assumptions with my supervisors, which they, in turn, could challenge. This process is further explored in Chapter 5 when discussing my use of reflexivity throughout the research process.

Kvale (2006) highlights the importance of reflecting on the relationship that

exists between the interviewer and the interviewee. I used reflections to explore if the interactions between the participant and I were affecting the data collection. I particularly focused on my own ideas around self-care and self-compassion and the fact that I am able to utilise these within my professional and personal life. I also reflected on my assumptions, thoughts and values that have developed during my career in nursing.

Reflexivity or ‘owning one’s own perspective’ has been advocated as a fundamental concept in ensuring the quality of qualitative research (Elliott et al, 1999; Henwood & Pidgeon, 1992). Silverman (2001) identifies the importance of keeping a reflective diary or log in order to encourage critical self-awareness. This self-awareness, through use of a journal, helps to highlight how the researcher’s own perspectives may be affecting the analysis (Charmaz, 2006). Within the constructivist approach this is not viewed as problematic as an emphasis is placed on the co-construction of theory from the collected data (Charmaz, 2014). In being reflexive the researcher must continuously examine and explore her relationship through all stages of the research process (Conrad et al, 1993). As stated, a reflexive journal was used throughout the research process to ensure a constant awareness was maintained (see Appendix 12 for an example reflexive journal entry).

My roles and responsibilities as a nurse researcher were clearly defined and outlined from the outset of the study in the participant information sheet (see Appendix 6). Moule and Goodman (2009) identify that nurses must make it clear to their research participants that they are undertaking a research project and that they are acting as a researcher rather than as a nurse. My role as a nurse, researcher, and therapist in clinical practice will be further explored in chapter 5.

3.26 - Timing of the literature review

There has been much debate within the Grounded Theory community as to when the literature review should take place. Glaser and Strauss (1967) advocated that researchers should begin the research process with an open mind; therefore, they advised delaying the literature review until after completion of data analysis, to avoid importing and imposing prior knowledge and preconceived ideas onto the

data. Their advice was '*literally to ignore the literature of theory and fact on the area under study, in order to assure that the emergence of categories will not be contaminated*' (Glaser & Strauss, 1967, p45). Heath and Cowley (2004) stated that this can be challenging for a researcher, arguing that hardly anyone will enter a field completely free from the influence of past experience and reading. An initial review of the literature can also be helpful in narrowing down the topic of enquiry, identifying gaps in knowledge and setting the scene for a study (Wilson, 2012). Glaser and Strauss later diverged on their stances about conducting a literature review before data collection (Ramalho et al, 2015), but both shared the core notion that a theory should be allowed to emerge from the data. Glaser argued in favour of no reading on the topic of enquiry, whilst Strauss and Corbin recognized that a researcher brings personal and professional experience and an acquired knowledge of the field of enquiry (Strauss & Corbin, 1990). They also claimed that engaging with the existing literature could help the researcher to identify what is important to the developing theory (Hickey, 1997), so long as the researcher maintains an attitude of scepticism (Strauss & Corbin, 1990).

Charmaz (2006) recognises that researchers will often review the literature prior to data collection and use this to aid the formulation of research questions and field of enquiry. However, she advises that once reviewed the literature should '*lie fallow*' until later stages of the research to encourage the researcher to develop their own ideas (Charmaz, 2006, p166). I completed a literature review prior to commencing the study in order to identify gaps within the knowledge base and to aid justification and rationale for my research. I only returned to the literature following completion of my data collection and initial analysis in order that I developed my own ideas and concepts. Returning to the literature at this point assisted in further analysis and the formation of ideas. This will be further discussed in Chapter 5.

3.27 – Ethical Research and Development Approval

Approval to conduct the study was sought from the University of Warwick's ethics committee (BSREC – REGO-2015-1614) and also from relevant NHS Research and Development departments, which included letters of access, a research passport and basic IRAS approval for the sites and research and

development (CWPT280815A). As the research did not involve direct contact with patients, full NHS ethical approval via IRAS was not required (see Appendix 13).

3.28 – Ethical Considerations

This section outlines the broader ethical issues that were addressed in preparation for the study and as an ongoing process throughout. These are underpinned and structured by four key principles: respect for autonomy, beneficence, non-maleficence and justice (Beauchamp & Childress, 2009).

3.28.1 - Respect for autonomy

Respect for autonomy can be defined as the need to acknowledge a person's right to make choices, to hold views and to take actions based on personal values and beliefs (Beauchamp & Childress, 2009). Due to this, participants were well informed and understood their rights within the study.

a) Privacy, confidentiality and data storage

Participants were given assurance that any identifying information would be removed in all transcripts, publications and presentations of the research. Information about the study made clear that data about participants would not be shared with anyone not directly involved with the study without prior consent from the participant, unless the researcher was concerned about the risk to this individual or others, or for research monitoring and auditing purposes.

Each participant was allocated a code to ensure confidentiality. These were kept in a file containing the identity of the participant and their corresponding code. Data were kept in a locked filing cabinet at the University, and on an encrypted memory stick. The confidentiality and data protection information was fully explained to potential participants in the written information sheet and consent form (see Appendix 4). Data were stored in accordance with University research procedures ⁵.

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It was made clear to all participants that they were free to withdraw from the study at any time, without giving a reason. They would then have the option of their collected data being used or destroyed. This situation did not arise within this study, with no one asking to withdraw.

b) Informed Consent

Potential participants were provided with an information sheet outlining the purpose and procedure for the research. Potential participants were given time to consider taking part. They had the opportunity to ask questions and to address any matters arising from the information sheet prior to consenting to participation (see Appendix 14).

3.28.2 - Beneficence and non-maleficence: Balancing risk

Beneficence can be defined as ‘doing good’, in providing benefits to individuals and contributing to their welfare, predominantly referring to an action done for the benefit of others (Beauchamp & Childress, 2009). Non-maleficence means to ‘do no harm’, having an obligation not to inflict harm intentionally (Beauchamp & Childress, 2009). These two principles were considered in terms of the benefits and potential distress the research may cause due to the nature of the topics being discussed.

a) Interview content

Plans were made about managing distress that may occur as a consequence of participation in the study. I addressed this, and identified that I could liaise with other services if deemed necessary. If an individual did become upset or distressed, the interview and its recording were to be stopped and the participant asked if they wished to continue. If they decided to continue I would check at the end of the interview that they felt ok and if they had someone they could talk to about their concerns or distress. I used my clinical experience to assess when additional support was required. Some upset and distress did occur during the interview process and the participants were asked if they were ok. All wished to

continue and those that became upset or distressed identified that they found the process of the interview and the face-to-face discussion useful. At the end of the interview recording the participants were given time to reflect and I was able to check that they were ok. No participants required any follow up support.

b) Sensitive disclosures

If any practice was disclosed which was deemed dangerous then this must be acknowledged and dealt with in accordance with local policy and procedure. Participants were to be encouraged by the researcher to report and discuss any concerns or issues if they arose with their manager if they had not done so already. Responsibilities of disclosure within the principles outlined by the Nursing and Midwifery Council (NMC, 2015) would have been upheld if required. However, there were no such incidences within this study.

c) Safety

If an interview took place in a participant's home then lone worker guidance was followed. This guidance is in place within NHS settings with the principles of maintaining safety being employed for the purpose of this study⁶. To maintain safety at all times, the researcher phoned an allocated individual (e.g. supervisor) on entry and also on leaving the property. Only one participant opted to have the interview conducted within their home and two at the University, with all other interviews being conducted in a private space within a clinical setting.

3.28.3 - Justice

Justice is defined as the need to treat others equitably and distributing benefits or burdens fairly (Beachamp & Childress, 2009). For the research to maintain a fair and non-discriminatory participant selection, the study was open to all registered nurses regardless of nursing discipline across both study sites. All participants were able to express an interest in the study and gain access via face-to-face contact, email or telephone call. A number of individuals who expressed an interest in the study were not interviewed due to a lack of response to further email contact or difficulties with arranging a time to meet. All those who

⁶ http://www.nhsbsa.nhs.uk/Documents/Lone_Working_Guidance_final.pdf

expressed an interest will be given the opportunity to see the findings of the study.

3.29 - Rigour

Rigour was demonstrated by the application of four criteria for trustworthiness as proposed by Charmaz (2006, p182):

- *Credibility is the extent to which the study and its findings are plausible.*
- *Resonance can be achieved where deep insights into participants' experiences are found and it makes sense to them.*
- *Originality depicts the ability of the findings to provide new insights into the phenomenon.*
- *Usefulness relates to how well the research has captured the participants' practice and how relevant the findings are to their practice.*

Charmaz (2014, p337-338) suggests the use of the guiding questions listed in Table 17 to examine trustworthiness of an entire research study:

Table 17: Guiding questions to ensure research trustworthiness

CREDIBILITY
<ul style="list-style-type: none"> -Has your research achieved intimate familiarity with the setting or topic? -Are the data sufficient to merit your claims? Consider the range, number, and depth of observations contained in the data. -Have you made systematic comparisons between observations and between categories? -Do the categories cover a wide range of empirical observations? -Are there strong logical links between the gathered data and your argument and analysis? -Has your research provided enough evidence for your claims to allow the reader to form an independent assessment – and agree with your claims?
ORIGINALITY
<ul style="list-style-type: none"> -Are your categories fresh? Do they offer new insights? -Does your analysis provide a new conceptual rendering of the data? -What is the social and theoretical significance of this work? -How does your grounded theory challenge, extend, or refine current ideas, concepts, and practices?
RESONANCE
<ul style="list-style-type: none"> -Do the categories portray the fullness of the studies experience? -Have you revealed both liminal and unstable taken-for-granted meanings? -Have you drawn links between larger collectivities or institutions and individual lives, when the data so indicate? -Does your grounded theory make sense to your participants or people who share their circumstances? Does your analysis offer them deeper insights about their lives and worlds?
USEFULNESS
<ul style="list-style-type: none"> -Does your analysis offer interpretations that people can use in their everyday worlds? -Do your analytic categories suggest any generic processes? -If so, have you examined these generic processes for tacit implications? -Can the analysis spark further research in other substantive areas? -How does your work contribute to knowledge? How does it contribute to making a better world?

Charmaz (2014) recommends a strong combination of originality and credibility in order to increase resonance, usefulness and thus the value of a study's contribution to knowledge. Credibility incorporates the need to adopt well-established research methods (Shenton, 2004). The use of Grounded Theory and

the adherence to its guidelines within this study enhanced the credibility of the current research. An impetus is also placed on the development of familiarity with the research setting and its participants (Erlandson et al, 1993). As I am a nurse and have worked in both research settings this aided familiarity and participants verbally reflected that they felt I was approachable and understanding of the environment in which they worked and the experiences that they had been through. The possible downsides of this are further explored in chapter 5. Polit and Beck (2008) identify triangulation as a way of improving credibility, by drawing on the use of different data collection methods in order to add strength to the study. Within this study data were collected from a range of sources, with nurses working in different nursing disciplines, over two NHS trusts. Triangulation was also achieved through the process of discussing the data with two supervisors. A focus was placed on encouraging honesty within the sampled participants by ensuring confidentiality, allowing easy withdrawal or refusal to participate within the study should they feel unable to provide an open account of their experiences (Polit & Beck, 2008). Shenton (2004) proposes the need for a thick description of the phenomenon under study, with Silverman (2001) supporting this and also advising a return to the literature to examine previous research findings. The term 'thick description' was first used by Ryle (1949) and refers to a detailed account the researcher makes regarding patterns of cultural and social relationships and putting them in context (Holloway, 1997). The term is often heard more often within ethnographic studies (Geertz, 1973). This was addressed within the current study by keeping detailed notes following each interview, primarily consisting of observations and reflections on the topics discussed, the relationship in the room and any specific topics raised that related to the context in which a participant worked. For example, one person felt they had been treated 'badly' within the trust they worked for, and this formed a basis for the issues discussed within their interview, but this did not translate to others working in the same context. However, overall a pattern emerged for many of the participants to express feeling unsupported in their working environments.

Resonance was demonstrated using two approaches. Firstly, theoretical saturation or sufficiency was reached after interviewing thirty participants, whereby no new data, leads or issues were arising and categories were

sufficiently dense. Secondly, member checking was utilised. Sandelowski (1993) identifies the twofold purpose of member checking as gaining feedback from participants pertaining to the interpretation of the data collected and allowing participants access to their data. Disadvantages of member checking are outlined in the literature, and include: participants telling the researcher what they want to hear; it may require skills and experience from the researcher which can be time consuming and sometimes the content of interviews may be distressing (Morse et al, 2002). Birt et al (2016) identify *'within a constructivist epistemology, it can be used as a way of enabling participants to reconstruct their narrative through deleting extracts they feel no longer represent their experience, or that they feel presents them in a negative way'* (p1803). This is often questioned in terms of who 'owns' the data, the researcher or the participant? Within member checking, participants are asked to view their own spoken language, which can be welcomed by some but disliked by others (Forbat & Henderson, 2005). Throughout each interview, para phrasing and summarising were utilised to check my understanding of what the participant was saying. I also sent each participant their transcript to review, and add or remove anything. All participants were happy with their transcripts, with no data being removed aside from a couple of words, which they felt could impact anonymity. Dickenson-Swift et al (2007) posit that some participants may become distressed during the interview but acknowledge that this can also occur during the process of member checking when a transcript is sent to them. I sent the participants their transcript via email and checked that they were ok following receipt and having read it. No distress was disclosed and all were grateful that they had been sent a copy. There is an argument as to whether member checking should take place during or post data collection (Miles & Huberman, 1994). However, Sandelowski (1993) describes it as an ongoing process.

Due to the dearth of existing knowledge relating to self-care and self-compassion in nursing, originality and usefulness were demonstrated by offering new insights and the development of new concepts and a core process as discussed in chapters 4 and 5. These findings and new insights may have implications for future nursing practice, education and policy (see chapter 5). Shenton (2004) states *'the results of a qualitative study must be understood within the context of the*

particular characteristics of the organisation or organisations...in which the fieldwork was carried out' (p70). Therefore, for the purpose of my study the results must be easily understood and relate to the current issues being experienced by the nursing workforce in order that they may inform future research.

3.30 – Summary

A qualitative methodology was chosen, in particular Constructivist Grounded Theory, with a view to exploring and identifying emerging themes and theories, which could explain the phenomena of interest. Purposive sampling followed by theoretical sampling was used and individual interviews with nurses were conducted as the main method of data collection. A total of thirty interviews were completed across different nursing disciplines, with nurses at a variety of stages in their career, from newly qualified to three months until retirement. I closely aligned myself with the method proposed by Charmaz (2014) to produce a valid Grounded Theory study. The next chapter details the findings of the study. It uses quotations from participants to illustrate the emerging categories, theories and final construct from the data analysis.

CHAPTER 4

STUDY FINDINGS

4.1 – Introduction

This chapter presents the study findings from the qualitative data collected for the thesis. As discussed in Chapter 3, the data consisted of 30 interviews conducted with nurses, which explored their experiences of self-care and self-compassion and how these experiences may relate to compassionate care giving.

A number, used to identify the source of quotations, identifies participants in this chapter. Below is a repeat of Table 14 found in Chapter 3 to aid reader reference when interpreting the data:

Table 18: Participant characteristics (Repeat)

Participant Discipline and Number	Years qualified	Role	Band	Length of interview
RGN1	11	Non-Clinical Role	Band 6	1h01m51s
RGN2	29	Senior Clinical Role	Band 8a	45m54s
RGN3	39	Non-clinical role	Band 7	44m55s
RGN4	36	Clinical Role	Band 6	1h17m14s
RGN5	9	Clinical Role (Trained outside of UK)	Band 6	38m57s
RGN6	32	Clinical Role	Band 6	27m47s
RGN7	29	Clinical Role	Band 6	35m35s
RGN8	12	Clinical Role	Band 6	31m26s
RGN9	17	Clinical Role (Trained outside of UK)	Band 5	35m26s
RGN10	40	Senior Clinical Role	Band 7	1h 21m18s
RGN11	11	Senior Clinical Role	Band 7	36m50s
RGN12	30	Senior Clinical Role	Band 8b	1h07m12s
RGN13	7	Senior Clinical Role	Band 7	41m41s
RGN14	29	Senior Clinical Role	Band 8a	44m38s
RMN1	3	Community Clinical Role	Band 6	1h06m29s
RMN2	1	Community Clinical Role	Band 5	26m43s
RMN3	6	Community Clinical Role	Band 6	57m53s
RMN4	5	Clinical Role	Band 6	58m03s
RMN5	31	Senior Clinical Role	Band 7	1h06m02s
RMN6	28	Senior Clinical Role	Band 7	1h03m07s
RMN7	4	Community Clinical Role	Band 5	41m28s
RMN8	8	Community Clinical Role	Band 6	38m45s

RMN9	15	Community Clinical Role	Band 5	26m40s
RMN10	28	Community Clinical Role	Band 6	47m17s
RMN11	19	Senior Clinical Role	Band 7	54m57s
RMN12	31	Senior Clinical Role	Band 7	1h31m54s
RMN13	16	Senior Clinical Role	Band 7	44m09s
RNMH	7	Community Clinical Role	Band 6	55m02s
DQ1	33	Senior Clinical Role	Band 7	56m56s
DQ2	31	Senior Clinical Role	Band 7	59m12s

4.2 – Context and Environment

Three participants chose to be interviewed in their own time with the remaining 27 interviewed during their working hours. As only one participant opted to be interviewed in their own home environment, I was unable to establish any differences in the data collected based on this variable. All environments were felt to be conducive to the interview process. The three individuals that were interviewed in their own time still had certain pressures, which restricted the time available for interview completion; one had childcare issues and the other two were interviewed prior to commencing a nursing shift. That participants were willing to dedicate their own time or take time out of their work to be interviewed showed a motivation to engage in the topic of study, which is further explored in Chapter 5.

4.3 – Handling and analysing the data

Interview recordings were listened to and initial notes and reflections made. They were transcribed verbatim and manually coded on paper, and further coded using NVIVO 10, utilising the coding process proposed by Charmaz (2014) that is outlined in Chapter 3.

Throughout the analysis I held the original research questions in mind:

- What are nurses' experiences of self-care and self-compassion?
- How do these experiences relate to compassionate care giving?

The following sections present the findings as three concepts in relation to the

research questions:

4.4 – ‘Hardwired to be caregivers’ –Vocation versus role

4.5 – Needing a Stable Base

4.6 – Managing the emotions of caring

How these concepts relate to the study’s core concept of ‘Needing permission to self-care and be self-compassionate’ is then presented.

Tables 19, 20, 21 and 22 illustrate how each concept was developed from the coding process and the creation of categories. Using the principles of constructivist grounded theory (Charmaz, 2014) the categories identified in this study were drawn from participants’ responses.

Findings in respect of the core concept ‘*needing permission*’, which connects and relates to all three concepts, will be discussed within sections 4.4-4.6. A focus will then be placed on the final conceptual framework, the Grounded Theory, presented in section 4.7. Key verbatim quotations from the 30 nurse participants will illustrate how these findings were developed and concepts reached. Before presenting these concepts, descriptions of key terms underpinning the thesis are outlined in order to ascertain how participants related to them and made sense of them within their own experience.

4.4: Concept 1 – ‘Hardwired to be caregivers’ –Vocation versus role

Table 19 depicts the coding process that led to the concept of ‘Hardwired to be caregivers’- vocation versus role. Key quotations from participants will be used to show the importance of this concept and how it links to the core concept of ‘needing permission’. Participants discussed their understanding of the concepts underpinning this research (compassionate care, self-compassion, self-care), and how they related to their professional and personal identity. Their responses linked to motivations for becoming a nurse. They were very open and able to express their reasons for embarking on this career path, recounting their own nursing story and journey.

Table 19: Concept 1 – ‘Hardwired to be caregivers’ – Vocation versus role

Concept	
‘Hardwired to be caregivers’ – vocation versus role Becoming and being a nurse	
Categories	
Nursing Identity	Motivating Factors
Codes	Codes
Understanding the concepts	Training and experience
Nurse as self	Background and early experience
Nursing as a role	
Nursing character	
Possessing compassion	

I) Nursing Identity:

Understanding the concepts

Participants were asked to talk about their understanding of the terms self-care, self-compassion and compassionate care before an exploration of their experiences with these concepts took place. This understanding or lack of understanding appeared an important aspect of their identity, due to the accessibility of the concept and what may be blocking or facilitating it.

As shown in Chapter 2, a number of definitions exist, which place a focus on self-care being promoted toward the patient. It was expected that participants would have some understanding of this term prior to taking part in this research, due to self-care being a familiar concept within nursing in areas such as the management of long-term conditions (Supporting people with long term conditions to self-care, DoH, 2006; & Self Care – A Real Choice, DoH, 2005).

Most participants felt that self-care suggested a holistic approach to wellbeing,

as suggested in the following quotations:

'I think it is about looking after your own wellbeing, so not just about your own physical health erm but it's about looking after your mental health, your emotional wellbeing erm and just kind of making sure you have good work life balance and time outside work' (RGN2)

'I suppose it is about looking after yourself isn't it, it's about making sure that you're well and healthy, not only on a physical level but on an emotional and mental level as well, erm but I suppose I find that quite hard to define' (RNMH)

The above quotations suggested an onus on the self, with a focus on self-control, and the locus of control as an internal process. Discussing self-care led participants to reflect on their own health and wellbeing and the process of recognising when they were unwell and needing to address this. Interviewees were quite good at expressing a need to focus on their self-care, but suggested they struggled to act on this, and showed an inability to prioritise their own health. There appeared a perception that they existed at the bottom of the 'pecking order', caring for everybody else in the first instance and feeling guilty when contemplating self-care:

'it's almost like we feel guilty if we self-care so I think we're very busy perhaps, not looking after perhaps or caring for, coz we come into nursing usually because we're caring and I think quite often we care for everybody else around us, not just patients and relatives, service users but perhaps colleagues, perhaps our family and I think if you did that on a huge scale you know yourself, you would be right down at the bottom of the pecking order' (DQ1)

Participants also made links between self-care and care giving:

'Self-care is the time that you give yourself to make sure that you're physically, emotionally, having that time to, making sure you take care of

yourself really. We're no good to patients if we're not on top form'
(RGN11)

A need to be on '*top form*' was painted as important in order to serve others, which links back to the nursing code (NMC, 2015) and the idea that nurses should be well enough to care for their patients. Participants appeared to understand self-care and the components that make up the term, yet it seemed difficult to enact due to a need to prioritise others and consciously or unconsciously placing themselves at the bottom of the '*pecking order*'.

The term self-compassion was more difficult for participants to define. Many acknowledged their understanding of the term compassion but self-compassion led to confusion, with some participants not recognising it at all:

'I mean compassion's a big focus isn't it at the minute, in the trust values and erm the six C's isn't it (yes), so I know what it is but I've never heard of the self-compassion' (RMN2)

'it's a big word that's up there in the trust values but I think they direct it more to the patients than they do to the staff' (RMN5)

RMN2 had been qualified for 1 year and RMN5 31 years, showing that experience may not relate to an understanding of this concept, but rather an understanding may relate to other factors, such as early key messages and role models, as further explored later in the chapter. Participants who had not come across the term were given the opportunity to think about what it might mean to them:

'I've heard compassion coz it's part of our erm our mission statement as a trust (yes), erm but self-compassion I'm not quite sure what you mean by that, do you mean just being good to yourself' (RGN13)

'so just as we're expected to show compassion to somebody who is in dire straights or hurts themselves or whatever we should think about doing that for ourselves too' (RGN4)

From the above, participants were able to show a level of understanding by first thinking of the flow of compassion outwards towards others and then contemplating the idea of the need for the flow of compassion to be focused inwards. Data identified a strong need for self-compassion in order to be a 'good nurse', however this led to some conflict as self-compassion was not always accessible despite nurses being 'good' at their job:

'if there's no self-compassion element in whatever you're doing you, I don't think we'd be good nurses' (RGN9)

Other participants were able to more confidently define what self-compassion meant for them, reinforcing many of the definitions found in the literature, particularly those factors defined by Neff (2003), focusing on kindness, self-protection and common humanity:

'we're human aren't we? We are human and our feelings are valid (yeah), you know and even if somebody else doesn't get why you're feeling a certain way, you feel that way for a reason so it's valid' (RGN8)

'I think about sort of erm protecting yourself, so that emotional protection that we give ourselves' (RMN3)

The preceding quotations suggest that self-compassion was associated with a need to understand and manage emotions, relating to the ideas around emotional intelligence presented in chapter 2. There were no clear differences relating to discipline, gender or years of experience between those participants able and unable to define self-compassion, suggesting that other factors impeded this concept from being understood or accessed.

There was also a need to be able or willing to contemplate emotions as a means

of coping and as a means of being able to care for others:

'If you understand your own emotions, your own behaviours then you can appreciate others even more' (DQ2)

'I think if you're struggling with your own emotions you can't hold everyone else's as well (ok) and I think you have to be in an ok place yourself in order to do it' (RMN3)

The core concept around permission began to emerge in the data when asking for definitions of self-compassion:

'it's about being kind to yourself, being caring, you know, respecting yourself erm feeling loved, all of those things that every human wants to feel really (yeah) erm to be able to erm feel that way about yourself, to like yourself I suppose and to feel that you have permission to do things, that you're worth it and actually you know I need to do this for me' (RGN14)

'I think for me self-compassion probably would be more about, I think it's probably more about thinking about the impact of things that happen to you, or is happening to you and on you as a person and you as a professional erm but I also think it's giving you permission not to be able to answer everything in terms of your working life, and being able to say do you know what I don't know, coz I can't know everything' (RMN13)

Data showed recognition of the complexity of applying self-compassion and the need for commitment and active engagement, resonating with ideas presented by the Dalai Lama (2001):

'I think it's really important, erm it's a difficult skill to learn though, erm boy I'm still learning it, erm so yeah so self-compassion would be kind of going easy on yourself if you like' (RMN1)

'if we were trying to teach erm self-compassion, it's not straightforward it's incredibly difficult just to define but to lead someone into that erm it's incredibly difficult' (RNMH)

There was a feeling of sadness from some participants for those who did not understand the meaning of self-compassion, who were *'so busy doing for others'* (RGN14) they neglected their own well-being, putting themselves at risk of becoming *'very stressed and depressed'* (RGN8). There was also a suggestion that self-care was required in order to be self-compassionate:

'They are very linked I think that you have to be self-caring for you to have that self-compassion' (RGN5)

The concept of compassionate care appeared more comfortable and accessible for the participants. Participants provided their own definitions of compassionate care and what it meant to them:

'I suppose it's just being erm in tune to what's going on with someone erm and emotionally holding that and levelling with them erm showing quite a lot of empathy and kindness I think. It's probably not a great definition but it's mine.' (RMN8)

'I think it's just about being there for somebody, being able to listen, being able to hold their hand if that's what they need, being able to talk through their issues, being able to understand and empathise with some of the things that they may be talking about erm looking at things holistically rather than just at specific things...I don't know I have a feeling in me, I want to project or for them to feel that from me (right). I don't know what it is but that I care and if I can demonstrate that to somebody then I'll feel like I'm being compassionate.' (RMN11)

The idea of connecting with another human being was presented and being empathetic in order to achieve this:

'putting yourself in their shoes, able to see what their needs are, able to see their point of view, giving them time erm actually seeing how they feel, erm an outstretched hand is how I would describe it, yes, yeah, in both the physical sense and the mental sense (mmm), psychological sense.' (RGN7)

'it's about showing kindness, you know putting, reaching a hand out, showing human warmth' (RGN14).

Compassionate care giving was related back to themselves by identifying the need to treat others how they would want to be treated:

'I guess in a nut shell it's treating others how I'd want to be treated myself' (RGN12)

However, the need for mutual regard and trust - the patient understanding the role of the nurse and the nurse understanding the distress of the patient for compassionate care to take place - was also discussed. This suggested the idea of being able to see beyond one's own perspective, contradicting somewhat the above quotation relating to being treated as you would wish to be treated. Furthermore, it was noted that compassion and care had to exist alongside a motivation to bring about change in order to be a nurse:

'I think it would be very difficult to be a nurse if you didn't have care and you didn't have compassion and you didn't have the ability to want to make a difference to people's lives' (RMN11)

Questions relating to an understanding of the terms formed the early stage of the interview process. Self-care appeared easier to define, but for a variety of reasons it was difficult to apply. Self-compassion was less easy to define; for those who had an understanding of it's meaning, it appeared to be a complex term with many factors impeding its realisation. Participants throughout the interview process had little difficulty defining what compassionate care meant to them. The focus appeared to be on empathy and the ability to connect with another in order

to identify their care needs and be there for them. It also entailed treating others as you would want to be treated, whilst at the same time enabling mutual trust and a collaborative understanding of the role of the nurse and the patient, by seeing beyond one's own perspective. It is interesting to note that one of the key components of compassionate care depicted within the literature was lacking in participants' definitions, in terms of the alleviation of suffering and being active in this process. Key ideas from this section will be further explored as the chapter progresses.

Whilst discussing the terms and gaining an understanding of how the concepts were being experienced, numerous codes and categories emerged relating to the process of identity. Nursing identity as a theme was raised repeatedly throughout the first few interviews. Therefore, this was theoretically explored further, within the flexibility of the interview schedule and through the process of theoretical sampling. Two separate schools of thought emerged: nurse as self and nursing as more of a role.

Nurse as self:

This code captured the idea of nursing as a whole identity with a lack of sense of self outside of this realm:

'It's just me as a whole, I don't feel that it's a role. I think it's me as a person, as individual and I think it is very much not a vocation as such but it is, because I don't know whether I like that word so much but it is, it's just me as a being. I think I am a nurse being.' (RMN11)

Other participants echoed these thoughts:

'a lot of people say 'oh nursing is what I do', but a nurse is who I am and when I'm not at work I feel a bit lost' (RGN11)

'...coz it's who I am (laughs), like I say I've known from a very young age that I've always wanted to help people' (RGN13)

'I see it as part of my identity definitely' (RMN8)

The above participants had been qualified for a number of years and were very experienced nurses. They referred to a sense of vocation, with a drive to become nurses from a young age. This may impact upon caring for the self, if the desire or intrinsic need to care for others has been there for a long time. These ideas appeared to cut across the nursing disciplines and gender. The idea of nurse as self also appeared to be difficult to manage when unable to nurse, returning to the idea of a drive to care for others and a limited self outside of the nursing self:

'when I'm not at work I feel a bit lost (right that's interesting). I had a long bout of sickness...and I felt completely lost' (RGN11)

Participants reflected on how the public view nurses, highlighting that others often perceive the whole being as a nurse rather than as just a role, thus reinforcing the nursing identity:

'I think that sometimes people think that because you're a nurse and that's what you do for your job that you're always your job and you're always a nurse' (RMN7)

Again, this may impact on a nurse's ability to be self-caring, if there is a deep-seated social perception of nursing as an intrinsic part of their being, which is tied to caring for others. Public opinion will be further explored later in the chapter.

Nursing as a role:

There was an understanding that motivation for going into nursing may have changed over time, with a possible move away from the vocational path:

'...yes we do need degree level nurses...educated to a certain level but I think in doing that nursing has changed...if I'm blunt really. I don't think we always recruit the right people' (RGN14)

'I must admit I don't like the bit where people talk about it's an honour to be a nurse because I think how can it be an honour to be a nurse because all you have to do is apply for a course and get on it, you're not especially chosen really' (RMN13)

A reflection that the '*right people*' do not always enter nursing was presented, suggesting a shift in how nurses are recruited or a change in nurse education. Some participants highlighted the fact that anyone can apply to be a nurse, moving away from a 'calling', again showing a shift in thinking from vocation. There appeared a level of frustration when discussing this, placing the onus on the entrance of nurses to the profession as shaping later practice and experience. However, some participants did see nursing as a role and showed a degree of separation from their self:

'It is a job and it's not a vocation I do believe it is a job that anybody can do with appropriate training' (RMN12)

The above participant had been qualified for thirty-one years and spoke about a change in her view of nursing over this time, seeing it as more of a role due to how she had been treated within her workplace. This appeared to affect her ability to give herself permission to self-care and be self-compassionate, largely due to a wavering loyalty; she was more able to think of attending to her own needs as she moved away from an attachment to and demands of the organisation.

The following participant seemed to hold a good work-life balance, which could be attributed to his view of nursing as more of a role, separate from his sense of self. Yet he did suggest that nursing should be about more than financial gain:

'it's a job, pays a mortgage, you know and you think you shouldn't be in it, you work with people, it shouldn't be about paying a mortgage, it's got to be for helping people, it's got to be' (RMN13)

The viewpoints put across in the preceding quotations highlight that nursing as self or as a role is not rigid and that actually the two can co-exist. This suggests

that whilst some individuals can feel they are ‘hardwired to care’, this may shift over time, encompassing both vocation and role.

As discussed in Chapter 3, memo writing was used, as recommended by Charmaz (2014), to further explore some of the ideas emerging from the data on nursing identity (see Box 1). Memo writing helped me to make sense of the emerging themes and ideas and how these related between participants. An additional question was added to the interview guide in relation to nursing identity to sufficiently populate and explore this category.

Box 1: Memo 1 – Nursing Identity

Nursing Identity – 27.01.16

Participant RGN13 discussed the fact that ‘a nurse is who I am’ reinforcing the focus of a nursing identity and the possible link or role this plays in the ability to be able to offer self-care and self-compassion and also how this impacts on care giving.

There appears to be a number of participants already who perceive their sense of self to be a nurse with little or no other sense of who they are outside of that. This appears to cause problems in pushing their own needs aside, in favour of always being available to nurse and care for others.

A smaller number of participants to date appear to see nursing as a role and are able to switch off from being a nurse, and relate to other identities. However it is not clear as yet whether this group is more able to self-care and will therefore require further exploration in later interviews.

Nursing character:

Character traits and personality were raised within the data, further expanding on the ideas presented regarding nursing as sense of self. It was difficult to tease out specific traits. However, nursing was linked to an inbuilt need to save everybody and a natural ability to care for others:

'it is linked to personality but there is a thing with nurses that we want to save everybody' (RGN1)

'it's bred in to some nurses, you know you see something happening and you've got to deal with it' (RGN3)

The notion of '*ultra carers*' was suggested by participant RNMH to refer to individuals going above and beyond their expected remit, which was painted as negative because it meant the individual became too involved in the patient's case. This resonates with the definitions of compassionate care as described in chapter 2 and the question regarding how far a patient journey should be entered into.

Possession of a certain character was painted as desirable because nursing was considered a difficult profession:

'you've got to be erm you know a certain character, a certain personality erm it's such a rewarding job but it's a hard job, it's hard work you know, harder than it's ever been' (RGN14)

The literature suggests a need for hardiness and resilience within the nursing character, yet participants did not elaborate on what constituted a nursing character, focusing instead on the ability to be and act in a particular way in order to cope with the demands of the job. The discussion around character and personality led to questions regarding what makes a compassionate person and whether this can be learnt, with compassion appearing a central component of someone's character.

Possessing compassion:

Many participants felt that nurses were innately compassionate and this was one of the factors that led them into the profession. Hence, compassion was seen as part of their self and identity, giving them the ability to express their compassion in a work capacity:

'I think it's just something that comes out of you, that you want to identify so much with that other person suffering' (RGN4)

Compassion as part of the self links to the idea of nursing being tied to one's sense of self, within which compassion is viewed as either present or not:

'You can't switch it on and off, I don't believe you can (mmm), but again that's just me I can't switch compassion on and off, I'm either compassionate or I'm not and that's to whether it's a patient or a staff member' (RGN12)

There was also the idea that compassion cannot be taught, resonating with the study conducted by Bramley and Matiti (2014), explored in Chapter 2. However, it was noted that people can be placed in situations that may reduce their level of compassion or their ability to display it, such as being in a position whereby one feels mistreated or undervalued within the work setting and feeling stressed due to increasing work demands were mentioned:

'my view is that you're born a compassionate individual or you're not but there are some situations that people are put in that reduce that level of compassion, their ability to display it' (RGN12)

Participants remarked that the ability to care must be present in order to become a nurse. This therefore suggested that it cannot be taught:

'you've attracted people who are of that mind set, you want to care for others, you are essentially carers, otherwise you wouldn't do the job. The nurses that aren't that way inclined tend not to be good nurses. So I think we are already in a sense hardwired to be, to be givers (ok), rather than looking after ourselves more' (RGN6)

The notion of nurses being *'hardwired to be care givers'* was a recurring refrain within interviews, which often came at the expense of caring for the self.

II) Motivating Factors:

Alongside identity, motivation to nurse was frequently seen in the data with participants accessing memories of what led them into nursing and their experiences during their nurse training. Participants were asked what prompted them to become nurses and to maintain their motivation throughout their nurse training. They talked about training and experience, early background and role models.

Training and experience:

Nurse training was often depicted as providing insufficient tools to prepare these professionals to be self-caring and self-compassionate:

‘when I first started as a nurse it was that, I didn’t even think about self-care as a concept....but there is nothing in the training programme about making me aware of self-care, there was nothing, erm and I think that when you, you know you look at the physical aspect of the job of which is quite significant, the emotional impact of our job is significant’ (RGN1)

There was a focus on the emotional impact of nursing and how insufficient tools were provided to cope with this. This reinforced the sense of being there to serve others often at the expense of the self. Participants focused on nursing education, with anger sometimes expressed that this was often blamed when nurses were unable to cope, suggesting an absence of responsibility and ownership:

‘I don’t know how much of it is a reflection of society as a whole, but I do think it’s too easy for us as trained nurses to cop out and say it’s the uni’s fault’ (RMN12)

RMN12 had significantly more experience than RGN1 and they were from different nursing disciplines, which may account for the differing viewpoints. One person reflected on how training shaped her and the ‘mode’ she was able to adopt, which was viewed as a barrier to her being able to give herself permission to apply self-care. This highlights how training may shape how nursing is perceived and approached:

'probably the hard core training which I got from my country. It has taught me however demanding it is you just, I get tuned in to some particular mode, just go on with it' (RGN9)

She was one of two participants who trained in other countries (RGN9 & RGN5). Participant 9 found the ideas discussed around self-care and self-compassion to be extremely emotive, causing her to become upset during the interview process. She reflected on the fact that she felt she should care for herself more and that being part of the current study had given her permission to do so. In contrast, participant RGN5 recalled being taught to care for herself as part of her training:

'In (country) you look after yourself first (ok), doing placement they would fail you if you don't look after yourself (right), you would fail placement for not looking after yourself (ok), putting yourself at risk for a patient, whereas here it's the other way round' (RGN5)

This presented two cultural perspectives, one focusing on patients first and the other putting the self first, which is further explored in chapter 5. These perspectives implied that self-care could be taught but did not refer to self-compassion.

With a focus on early training already established, another participant mentioned certain traits can be learnt and brought out later on:

'who you are, self-belief, self-determination, self-awareness, all those sort of things they're vital, they're vital. If you don't have that then you're going to struggle, but some people don't have it but you can bring it out of them, you can bring it out of them. You can engage them where you can develop that' (DQ2)

The above quotation seemed to indicate two differing viewpoints, the first being the idea that within the nursing identity pre-existing traits are present, prompting individuals to become nurses, but also that these traits can be learned during the process of training and beyond. Participant DQ2 seemed to suggest that

compassion is not innate but can be taught, which differs from the viewpoint of others. This may go some way to reflect the idea that if certain nursing traits can be learned, then self-care and self-compassion can also be learned. However not all participants believed compassion could be taught, suggesting an individual focus and linking back to individual nursing character.

Participant DQ2 stressed the importance of early role models, which may explain his ideas around being able to teach or develop compassion:

'I certainly can still think about people that have influenced my clinical life, they were stood out as role models. I thought I want to be like that person, because they were amazing and those energized words and those behaviours are sadly lacking now, they're lacking' (DQ2)

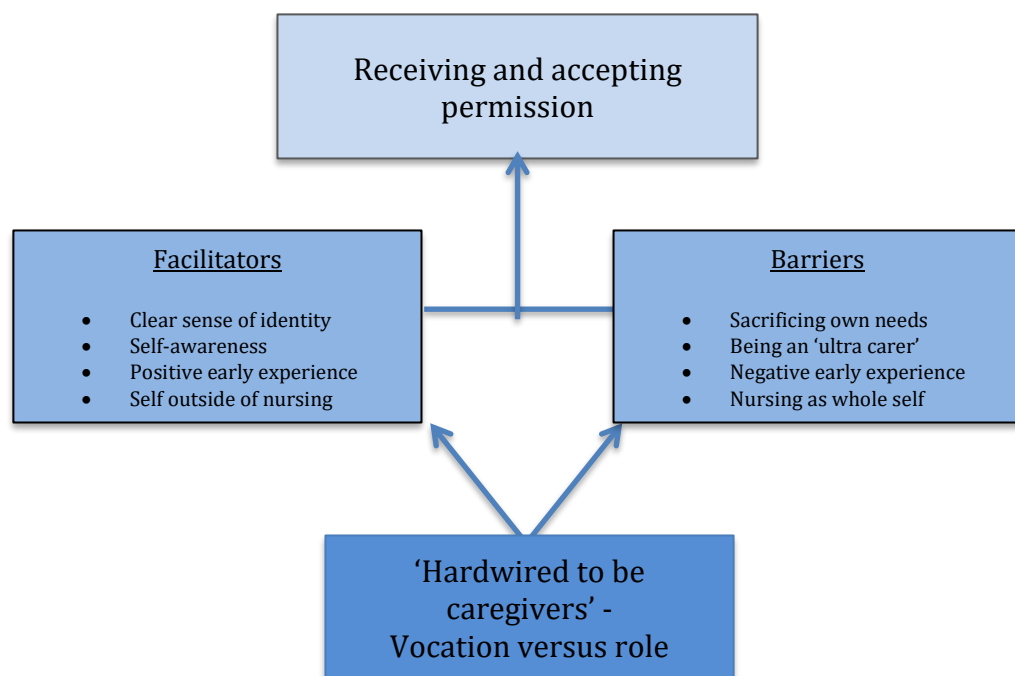
This highlights the importance of early messages and observed behaviours in shaping the nurse he became. Other participants also placed a focus on early role models, either within their nurse training, their early nursing career or during their upbringing. For example, participant RMN7 spoke of her parents and the fact that they had encouraged her to care for herself from a young age. She was able to carry these early messages into her nursing career and reflected that she always ensured that she cared for herself, such as making time to have lunch each day.

Summary:

The journey to being a nurse appeared to be an important concept when looking at permission to apply and accept self-care and self-compassion. Nursing identity, incorporating character, sense of self and compassion as an inbuilt trait, link to the overall core concept of permission alongside motivating factors such as early experiences and training. These ideas will be further explored in section 4.7. The journey for each nurse is likely to be different, shaped by early influences, experiences and role models. Hence, individuals will have varying concepts regarding being a nurse, with some viewing it as a vocation and others more as a profession. There appeared to be a link between the ideas that if nursing is viewed as a vocation, with sense of self dominated by 'I am a nurse', an

element of self sacrifice may follow, making self-care and self-compassion more difficult. Another viewpoint appeared to be that if nursing is regarded as a profession and more of a role then self-compassion and self-care could be more accessible and acceptable. However, data suggested a lack of clear distinction between the two, with nurses often changing their viewpoints as their careers and experience progressed. Figure 4 below depicts the facilitators and barriers associated with the concept of ‘hardwired to be caregivers’ and how these may influence the ability to receive or accept permission:

Figure 4 – ‘Hardwired to be caregivers’ – Vocation versus role



4.5: Concept 2 – Needing a stable base

Data suggested a strong link with the need for a stable base and what may happen if this is not in place. Table 20 shows the coding process completed to reach this concept. This section discusses the facilitation of self-care and self-compassion when individuals experience a stable base or feel safe. Data also showed the impact on self-care and self-compassion when nurses feel uncertain and unsafe, with the absence of a stable base:

Table 20: Concept 2 – Needing a stable base

Concept	
Needing a Stable Base	
Categories	
Feeling Safe	Living with Uncertainty
Codes	Codes
Being supported and valued	Changing NHS Sitting in the minds of others
Caring for each other	
Effective leadership	

I) Feeling safe:

The data showed a need for nurses to feel safe and secure within themselves, within their teams and within the environment that they work:

‘you have to feel secure, you have to feel contained don’t you as an individual and as a team and everything else, because of, you know if one, if you start to not feel that, then it starts to spread out to everything else doesn’t it’ (RMN3)

‘it’s all about feeling comfortable isn’t it (yeah), walls have ears (laughs)’ (RMN5)

‘we are still apparently under review so for about three or four years we haven’t felt safe, we’ve always felt that our jobs are at risk’ (RMN6)

The above quotations identified an unrelenting atmosphere of threat and the impact this can have on how safe and contained individuals felt. There was an indication that if the threat is uncontained then there is a contagious element with the feeling *'spreading out'*. There was a suggested need to feel comfortable; some participants described feeling under surveillance, which indicated again the need for containment and security within the environment. Some participants discussed feeling *'jobs are at risk'* due to being continuously under review, linking back to the idea of constantly being watched and listened to. In contrast, RMN3 was able to acknowledge that she felt safe at work, identifying a more positive work environment as the reason:

'I'm lucky in that, even the wider core team that we sit within are, we all get along as friends so if you need something from someone, everyone's on your side so to speak, so you could go to anyone and say 'I'm having a really bad day' (ok), 'can we talk about this', or you know bounce some ideas around, but I don't think that's the same everywhere' (RMN3)

Like RMN3, for those participants who felt safer at work, they reflected that this was often due to feeling supported and as having a more positive culture within their work environment.

Having Support:

Participants reflected on the need for support within the workplace, focusing on what transpired when this was not provided or recognised as important:

'it's too much pressure and not enough support, you're forever being told that everything was wrong and nothing was right' (RMN4)

'there's not the training, there's not the recognition, there's not the support, there's not everything that everybody needs...it feels a little bit like we're on a treadmill (ok) every single day you know it's groundhog day, we go in and it's really hard to not let that effect your compassion (mmm), to not let that effect your motivation and your drive you know, and

that's really sad' (RMN6)

This could then have implications on how nurses looked after themselves:

'Sometimes it just feels that work isn't helpful (mmm) in looking after yourself, they don't promote an environment that helps you to look after yourself it feels' (RMN3)

This related to the organisation within which they worked, with participants identifying the need to create their own stable bases amidst the chaos elsewhere:

'I am looking at my little bit and thinking what can I do here, forget that outside there coz change is inevitable, we know that, but even so there's ways of introducing leadership throughout change but I'm gonna forget that chaos, I have to forget that and I have to focus on here and me and my staff and my team and this service we provide' (RMN6)

One participant talked of creating his stable base away from work as a means of coping:

'I have a beautiful life outside of work. My beautiful life theory (yeah), that's very important so it is about being able to cut off from, you give your all when you're here, you take it on the chin but when you're out of here you develop a completely separate life' (DQ2)

This suggested a need to create a separate safe space, away from a more threatening work environment, and focusing on what, as an individual, one could realistically alter.

Participant DQ2 reflected on his *'ethos'*, identifying the need for a happy, healthy staff team, thus making the connection between emotions and nurses' physical wellbeing. This was discussed as an ideal and what as a manager he had previously tried to achieve. Some participants felt their organisation did not recognise the necessity for staff to feel valued, or consider their needs and

security:

'I see that really as because employers are not taking responsibility for people's mental wellbeing (mmm) because pressure has increased and increased without any thought as to the impact' (RMN1)

When staff did not feel valued and supported, they were affected by this, hiding from their work area, showing signs of distress and finding it hard to look after themselves:

'people that I highly respected and thought were brilliant, brilliant practitioners that were competent people would be coming in, in tears hiding in our recovery rooms and sort of saying 'oh god I've got to go back' ...I don't think they're necessarily better or any worse than any other trust but I think they just do not value the resource they have and that's pretty apparent because we can't retain people' (RMN12)

In addition to feeling valued, the need for a stable base and the provision of a structure was important in enabling nurses to feel supported and cared for:

'there's no trunk that the branches come off erm there's no main stay and if that was there then maybe some of the bulk of that could be about, well whatever the environment is, whatever the changes are, whatever reactive stuff we have, this is the proactive bit and this is how we look after our staff' (RMN6)

'there is something about I think the staff being made to feel that there is a structure to support them while they're getting on with the day job in saying that actually this doesn't feel right and erm I just think they, they sometimes don't see that and they refer to 'the trust' a lot and I always say 'but you are the trust, we're it, we're the trust' (right), aren't we?' (RGN12)

This illustrated how ownership and responsibility as part of the nursing workforce were seen as important, rather than absolving responsibility to others

and using the idea of 'us and them' as a means of coping. Within this there was recognition of a two way process rather than placing the onus completely on their organisation.

There was a focus on some workplace cultures being positive whilst others were painted as detrimental:

'just look at the cultures, the workplace cultures individually as they are because some are amazing and some are so detrimental to your health'
(RGN1)

'I think nursing can be, nurses can be very harsh and critical to each other. It was one of the things that quite shocked me coming into the profession' (RMN1)

'I'm not sure you know in these bigger ward environments whether people get that sense of support, erm from each other and also I think that the doctors are quite remote from the nursing teams and they don't work as a team, everybody doesn't work as a team' (RGN4)

Participants talked about a focus on compassion as underpinning the ethos of organisations and hospitals, but this was not always experienced in their day-to-day work:

'sometimes recognition from other people helps, I think you know people work their arses off and it feels unrecognised a lot of the time, not in the team but I think higher up, you know and those little personal touches to things like you can send a generic email out to everybody in the trust and say well done and you're all doing really well but actually everyone's like 'well do you know what we do, do you know who I am?' (RMN3)

Caring for each other:

Within the culture of a supportive environment, a thread of caring for each other

emerged in the data:

'I think that it's really interesting to look at how we look after each other and how we look after ourselves' (RMN11)

This linked back to some of the ideas raised in the previous section, relating to responsibility, with some organisations providing a caring culture and others not. Participants reported a need to be able to give and receive compassion to and from each other, with this providing a more positive and enabling environment for self-care and self-compassion to take place. Some participants reflected that caring for certain staff (i.e. those perceived to be friends) was easier, adding that it can only take one or two members of a team to destabilize the environment:

'In order to support each other you've got to have a really good cohesive team and it only takes one or two that aren't playing ball and erm it starts having an impact on everybody else (ok) so I think there's definitely work that can be done around that' (RGN14)

At times nurses seemed to have forgotten how to care for each other and placed the explanation for this on the culture within which they worked:

'Why have we forgotten how to care for each other coz it just doesn't happen, it does not happen. It's a bullying, hostile, blame culture, as much as they pretend it's not' (DQ2)

This not caring for each other was generalised to nursing as a whole:

'I think as a profession we're not very good at looking after ourselves. I think we're not very good at looking after each other sometimes' (RGN6)

Pressures of work sometimes explained this lack of care:

'I don't think nurses are always compassionate to patients or to each other and as I said before I think some of that is about because they feel stressed

or worried about their workload, they're feeling anxious about that'
(RGN4)

On a more positive note, some staff had the ability to give themselves permission to look after and offload to each other in order to cope with 'traumatic' experiences. This was made possible by working within a supportive team, with participant RGN2 talking about feeling safe and trusting the staff she worked with:

'it could be so traumatic working in that area that erm we gave ourselves the space that you could just go, you could have time out, erm between yourselves where you could just go and debrief for half an hour and talk about things and I found that really useful and I do think that would be something that would be useful throughout the NHS really' (RGN2)

RGN2 held a senior position within the trust she worked for, therefore suggesting she had some control over the environment and measures she put in place to support her staff. This highlighted the importance of effective leaders in creating a stable base, which in some settings, has been made a formal process with the introduction of supervision models and initiatives like Schwartz rounds (see chapter 2).

Effective leadership:

Effective leadership appeared key within the data, with ideas related to this appearing early in data collection. Being managed and supported in a positive way was depicted as enabling for nurses. Yet participants identified how nursing lacked leadership, which was attributed, in large part, to the loss of senior, experienced staff:

'we've lost a lot of senior staff, loss of ward managers and it feels quite a scary place at the moment I think erm and that's just from an outsider looking in because I don't work there now (no), but from what I've seen and what I hear it's quite a scary place because that experience has gone'
(RMN11)

There was also an acknowledgement that leaders and managers faced the same issues as other staff:

'I know that they want us to look after ourselves and I know that they are compassionate to the work force erm but I guess the thing is they're also up against the same demands aren't they (yeah), and it comes down the way' (RGN12)

This underlined the humanity of leaders and the fact that nurses are in it together, in contrast to the 'us and them' mentality mentioned earlier:

'I think sometimes the managers are under threat as well, err you know 'you've got to get this done', 'you've got to do that' and then they have consequences to face if they don't, and that works its way down then and onto the shop floor as it were' (RGN3)

'that support built, perhaps for it to go all the way down through the system (ok), and if your managers aren't being, don't feel that they, they can take the time to do it for themselves, then it doesn't carry on down' (RGN6)

Thus, managers could feel threatened and this cascaded down to more junior staff, creating a fearful working environment. This could lead to staff feeling leaders were not compassionate to them:

'it's about them acknowledging, cause they do talk about compassion in their trust values, but actually it's about compassion to others, it's not compassion to us, so maybe a more understanding approach from work' (RGN11)

An emphasis was often placed on immediate managers working within the clinical environment, with some managers being able to recognise the impact nursing can have. This appeared related to respect for the role and contributions of nursing:

'the best wards I've worked on is where you have really good nurse managers who recognise that terrible things happen and that sometimes staff need time out to actually process that' (RGN6)

'the supervision I get from my team leader is good as well and we will sit and talk about those feelings and what it evokes in us and (yeah) that's really helpful I think. I think it's just acknowledging it sometimes and saying 'ok this feels like a lot at the minute, what's that about' (mmm), and trying to unpick it a little bit' (RMN3)

Some leaders reflected on their leadership role in relation to the power they may have to acknowledge challenges and bring about change:

'people like myself, our senior leaders in the organization, are really, really crucial to how staff on the ground and at the coal face are feeling in regards to having the permission to challenge and have a voice... being able to be visible and reassure them that actually 'we're fighting your corner' (RGN12)

The data suggested a need for a clear vision and leadership style if nurses are to feel they have a stable base, and also highlighted the fact that nurses do not wish to be uncompassionate but that this can be the case when they feel overwhelmed. Sometimes poor leadership had been observed, with consequences for compassionate care:

'I think the lack of direction, the lack of vision (mmm), the lack of structured leadership erm impacts on people's ability to be able, I think if you asked any nurse, no nurse wants to be uncompassionate towards other nurses, towards other people in general but I do see that happening' (RMN6)

This indicated a possible limit to the flow of compassion and the importance of strong, clear leadership in order to manage that process. There also seemed to be a need for consistency and coherence within the leadership of an organisation, as

a means of offering containment, which unfortunately was said to be often lacking:

'if you think about any successful organization erm be it private, be it industry, be it business whatever nothing to do with healthcare, they all have one, they have a very specific leadership style, you know there is clarity about that, there is a vision, there are values, there are behaviours and tasks that exhibit all of that. I don't think we have that in our trust, I don't think there's a specific consistent leadership style' (RMN6)

II) Living with uncertainty:

Throughout the data a thread regarding uncertainty emerged, with participants actively speaking about service restructuring, lack of staffing, change and jobs at risk. These appeared to have a destabilising effect on staff, which then impacted upon a number of things including the ability to be self-compassionate and self-caring.

Changing NHS:

Participants talked about increased pressure in the NHS, with some people describing how it is now run like a business, detracting from a caring underpinning:

'I would argue that I don't call it the struggling NHS I call it the broken NHS. From my experience from working here, it is completely broken. I believe it's broken to the point of, it is beyond repair' (DQ2)

'it isn't as it was years and years ago when the matron was the top, it's all they're business people and I think your true business person is not terribly good at compassion side because that really is seen as a weakness within business' (RGN6)

The effects of increased pressure, a business orientated approach and a broken system appeared to have a de-stabilising effect, with nurses feeling like they are 'automatons' rather than professional carers, with technical skills rather than

relational ones more highly valued:

'automatons springs to mind because it's all about task focused activities rather than a dynamic process where you respond to the environment and that's how nursing used to be. Mental Health nursing used to be about a dynamic process responding to the environment through visibility, engagement, presence and now like I say automaton is that the priority is that you've got to well I don't know you've got to do your paperwork' (DQ2)

There was a sense of inevitability and being unable to see beyond changes that are occurring within the NHS:

'I just think that some people can't see beyond that, they don't like what's happened (mmm) to the NHS. It is a very different place to be now (yeah), erm and I just think it, we're expected to do more for less erm resource' (RGN12)

This led to looking back to positive days of nursing, in order to reflect on previous experiences:

'I believe that I had the Halcyon days of nursing in the eighties and the nineties up until just before the two thousand period, yeah they were the halcyon days of nursing' (DQ2)

Box 2 shows a memo related to this:

Box 2: Memo 2 – ‘Halcyon days of nursing’

‘Halcyon days of nursing’ – 22.03.16

Participant DQ2 spoke about the ‘halcyon days of nursing’, during the 1980’s, 1990’s and early 2000’s. On further discussion the changing NHS and culture was blamed on the move to a more business like model.

Many of the participants reflected the changing face of the NHS and nursing in general with many reasons for the changes being cited, including the above. Other changes featured the change in nurse training, negative healthcare enquiries with lessons learnt, changing management structures, more experienced staff leaving ward based environments, a more threat focused environment and the constant restructuring.

This will require further exploration as to whether there is any research looking at the changes in nursing or whether it is a more narrative experience at present. It seems to be a recurring theme throughout the data.

A link has also been made around not being able to have fun at work anymore (participant RGN12). Why did this change? Have rules and guidance changed so much that staff feel unable to experience or have fun anymore. Is this reality or perception?

‘we gave ourselves permission to have fun and we don’t do that anymore (no) and I don’t think we’re good at doing that with our teams as well’ (RGN12)

Sitting in the minds of others:

The data suggested a shifting public perception of nursing, with this potentially creating an unstable base. There was the expectation that patients come first, but there was also a requirement to outwardly demonstrate that nurses are self-caring, potentially causing conflicting demands on individual caregivers.

Many participants spoke of the way they felt nursing can be perceived by the public. They talked about how nurses were previously viewed as angels, but the impact of negative health inquiries, such as Robert Francis’ (2013) report on Mid Staffordshire NHS Trust, contributed to a societal shift in this perception:

‘If I said to people when I first started I’m a nurse I would have been

perceived as an angel, you're absolutely wonderful, I don't know how we could manage without you ... I think certainly following mid staffs I think erm public perception has changed very much so erm so we're perhaps not seen as these, you know these wonderful beings as we once were, we're seen as maybe human beings that are fallible' (DQ1)

Reflecting back to the section on nursing identity, the above statement could potentially be destabilizing, with ability to rock core beliefs and sense of self.

Nurses appeared concerned about how they were perceived by their patients and how they sat in their minds. Patients were described as picking up on visual aspects of nurses' self-care, such as dress code and appearance. This indicated the need for nurses to show that they are attending to these needs:

'They judge us, by our presentation, as soon as you stand in front of them, then they judge, you know so your appearance and the way you talk and the way you relate to them is very very important, you know so. If you look after yourself I think they will be happy as well' (RGN5)

The public expectation to put patients first remains core to the viewpoint of nurses, however it is often viewed as a stand-alone concept, with a sense of self-sacrifice and in isolation rather than seeing a relationship between self-compassion and compassion to patients, thus the ability care for the self alongside others:

'I mean most nurses will always put patients first won't they? Erm the public expect that as well' (RGN3)

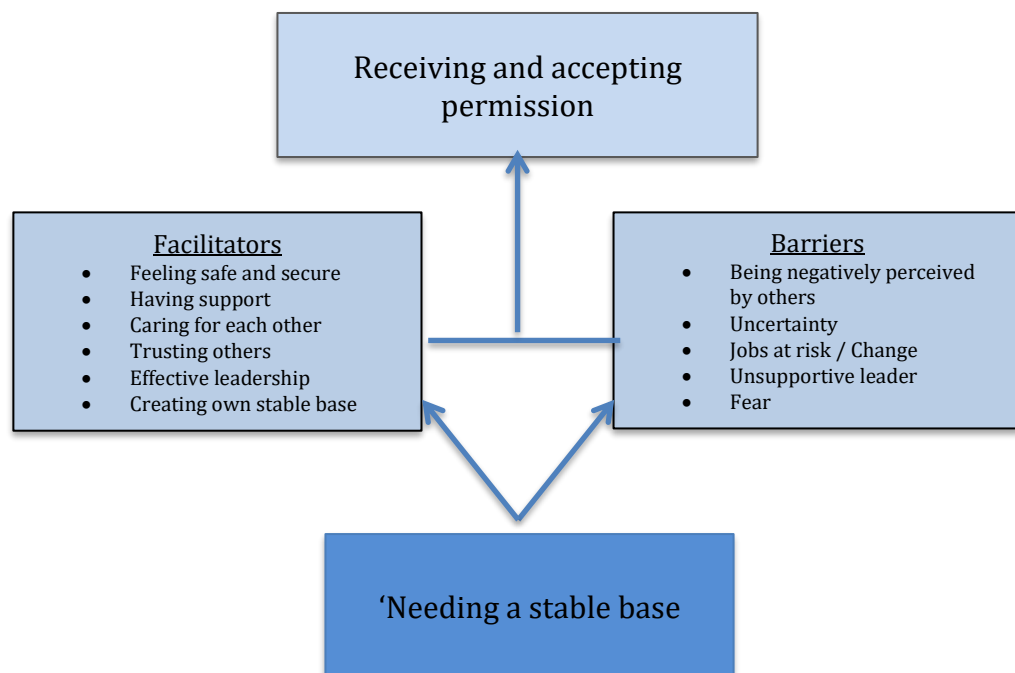
This will be further explored later in the chapter.

Summary:

This section has explored the need for nurses to feel safe and secure in themselves and their workplace in order to be self-caring and self-compassionate. A number of factors can and do get in the way of a stable base, such as the working

environment and having effective clearly defined leadership. This section showed how the changing NHS and public perception could interfere with a nurse's ability to feel safe and secure. Figure 5 below depicts the facilitators and barriers associated with the concept of needing a stable base, and how this relates to the core concept of permission:

Figure 5: Needing a stable base



4.6: Concept 3 – Managing the emotions of caring

Table 21 shows the coding process for the concept ‘managing the emotions of caring’ with a focus on the second research question for the study: *‘How do these experiences (self-care & self-compassion) relate to compassionate care-giving?’* This section centres on needing to care, benefits from caring and the impact of caring for patients alongside managing difficult emotions this can engender. It concludes by exploring the link between self-care, self-compassion and compassionate care giving.

Table 21: Concept 3 – Managing the emotions of caring

Concept		
Managing the emotions of caring		
Categories		
Needing to care	Learning to cope and manage	Struggling to recognise the need to cope and manage
Codes	Codes	Codes
Gaining from caring	Using compassion	Feeling stressed
Putting the patient first	‘Turning a page’	Offering too much
	Closing off	Burning out
		Refusing to engage
		Accepting a cycle of compassion

I) Needing to care:

Participants discussed their need to care for others, linking back to their identity as a nurse and the caring aspect of their character, which appeared to be emotionally driven and purposeful. They stated a need to care for others for a variety of reasons such as filling a gap, distracting them from difficulties or feeling lost if unable to do so. A sense of validation and reward in caring for people was evident. Personal issues can be put on the *‘back burner’* (RMN1) due

to patients coming first. This idea promotes a sense of self-sacrifice that may serve as a useful distraction from personal difficulties; self-care and the need to directly work on personal difficulties is pushed aside or blocked, due to caring for others taking precedence. This may then lead to more negative consequences of care giving discussed later in the chapter.

Gaining from caring:

Caring for others was sometimes depicted as a means to compensate for gaps in one's life by helping others:

'I think many of us like are trying to fill a hole in ourselves a little bit, so I think there's a big part of me that kind of erm kind of, I find fulfillment in caring for people... I find a sense of personal fulfillment and validation in caring for people that I didn't really get through other jobs' (RMN1)

Hence, receiving positive reinforcement from patients and directly from the care provided was perceived as a particular gain from caring:

'I think when you're providing compassionate care that sense of reward and achievement gives you a nice feeling inside you know a sense of satisfaction (yeah). I guess that's an element of self-care' (RMN2)

'I get support from positive comments from the people when you go round the wards, 'thank god you're on', those sorts of things, so you can get the value from your staff team. You get your value from your patients' (DQ2)

One person described how caring enabled her to attend to her religious beliefs:

'.... what you do on a daily work you do get your wages and that will keep you going for these earthly needs but when you do your good stuff you are kind of investing somewhere else as well' (RGN9)

This indicated a dual investment and the idea that by giving care to others and giving of yourself, you will be rewarded in the future or in the afterlife. Despite this focus on religious beliefs being only mentioned by one nurse, it illustrates

that individuals may have their own personal reasons for becoming a nurse, and that the gain from caring may vary from person to person.

However, sometimes the gain from caring was not enough:

'the patients tell us we're doing a good job and all of that is fantastic but I think the overwhelmingness of all the other stuff really erm overtakes, you know the bit of satisfaction that we have from the client feedback and the carer feedback' (RMN6)

Putting the patient first:

Whilst putting patients first was acknowledged as important it seemed there was a balance to be struck, which could be difficult to attain:

'I think it's the expectations at work and your own expectations as well because sometimes you impose pressure on yourself so it's not just pressure from people above you it's pressure within yourself to do the right thing, to look after your patients properly, because their needs, when you're at work in the nursing role, you always put their needs before yours (yeah), very much so, throughout my nursing career that is how I've been (ok)...It is finding a balance, you've got to obviously look after yourself but it's yeah others around you as well (yeah). I don't think I've ever really put my own needs above (laughs) other peoples, no I don't think I have' (RGN7)

'you always put your patients first and yes I always would put my patients first but actually if I've got no self-compassion for myself and I'm not looking after myself I can't give my patients a hundred per cent so it works both ways really, I would feel' (RGN14)

Hence, there was an acknowledgement that in order to give good care nurses needed to look after themselves. However, organisations expected patients to be put first:

'so you give away everything, just to nurse that patient, because that is what the hospital, yeah that is what the institution is about, caring for the patient. So that's what we do' (RGN5)

The message to put patients first and its reinforcement through the NMC code (2015) and guidance could be a barrier to self-care and self-compassion. There was also an accompanying tension regarding focusing on the self, with the fear that this may move them too far away from the patient. Participants began to acknowledge that much of the focus is placed on care of the patient and as a result questioned where nurses fit in this and who cares for them:

'so it's all about the patient, there is nothing really about us' (RGN5)

'we're always asked to look after patients, who looks after us' (RGN2)

There seemed to be some resentment at prioritising the patient at a cost to self, at being expected to cope until reaching breaking point:

'It's always them and you, you're there to do a job, you have to deal with that, you're not there to, you've gotta cope with whatever's thrown at you' (RMN4)

'To be honest because we are so much into doing for patients and all the trainings and everything is based around looking after patients, the first instant when you think of self-care you're thinking about patient first, and very little has been thought about to how I care myself' (RGN9)

Whilst participants needed to care and acknowledged a want or need to put patients first, the data suggested that nurses might struggle to manage the emotions associated with caring. Ideas and processes arose from the data identifying that there was a need to learn to manage the emotional components of nursing, with this then linking to how self-care and self-compassion are permitted and how they relate to compassionate care giving.

II) Learning to cope and manage:

Within the data it was clear participants focused on the more emotional aspects of nursing, rather than physical health and the negative impact that can be associated with caring for others. It appeared that often these negative aspects occurred when caring for the self was not taking place and nurses put themselves to the '*back of the queue*' (RGN10) and thus were in danger of '*falling off the edge*' (RGN12). This indicated a struggle to balance patient and a nurse's own needs, resonating with the ideas around putting the patient first, which could lead to a sense of helplessness, to being mindful as to what is happening but being uncertain about how to prevent it, or being unsure how to stop putting oneself to the back of the queue. A number of thoughts emerged within the data around ways of coping with the more difficult aspects of nursing, such as using compassion, closing off, and the idea that repeated exposure acclimatises the nurse to certain difficult events.

Using compassion:

The need to be self-caring and self-compassionate to prevent compassion outwards from becoming overwhelming was identified, as a way of managing difficult emotions that could be associated with nursing:

'I think people can probably provide compassionate care, the problem is their own wellbeing may suffer because, because they're not able to be self-compassionate or self-caring so that their compassion may be almost too great if you like in terms of looking after people and not looking after themselves' (RGN4)

If nurses are able to be self-compassionate, it was argued that they can reflect on their self-care and be more effective in their care giving, by attending to what is going on around them, This indicates that self-compassion may precede self-care, which is highlighted in the use of reflection to manage emotions:

'I think that if you've got the self-compassion it's about that reflection, it's about looking at yourself and if you're doing that you're also more effective in looking and reflecting at the care you're giving as well' (RMN13)

The above quotation links to the literature on emotional intelligence as discussed in chapter 2, with the need to be aware of difficult emotions in order to process them. Hence recognising when giving compassionate care becomes difficult, before it becomes overwhelming.

‘Turning a page’

The process of ‘turning a page’ to move on was described by some participants after experiencing a difficulty at work, but although the page is turned, it is always there to be revisited:

‘so you just turn a page over and when you go into nursing and the older staff do tell you that is what will happen and eventually that does happen with everybody... it’s like in the background, it’s still on the shelves’
(RGN8)

Hence, the page is returned to, when a similar experience occurs:

‘Yeah like the page opens and you can see it but you’re not actually in there, like but if something similar happens then erm it’s more of an impact if something similar happens because then you actually go back into the previous one and the one that’s happening, so then it affects you more because it brings back the emotions (ok) and the feelings that you had before’ (RGN8)

Whilst turning a page to move on appeared to be a means of coping with difficult experiences, it was acknowledged that previous emotions arise, indicating that it is a short term coping strategy that avoided rather than managed and resolved difficult emotions and experiences. This aspect of the interview led to the following memo in box 3:

Box 3: Memo 3 – ‘Turning a page’

‘Turning a page’ -01.10.15

Participant RGN8:

‘it’s like turning a page over, you’ve then got to, it’s always there but you have to like put it to the background and then you have to focus on the patients that are here and alive’

When we think about how we manage difficult incidents and move on, participant RGN8 talked of turning a page of a book, advising that she can return to it at any point but turning the page to enable herself to move forward and care for the next patient. Does this mean that these things always stay with us and what makes it possible to turn that page? Turning the page but learning from what has gone on before.

Exposure to human suffering by nurses is common (Dominguez-Gomez & Rutledge, 2009). Nurses may have different ways of dealing with this, but what leads some to burnout or become traumatised and what allows people to turn that page. Could this link back to emotional intelligence and resilience?

Von Dietze & Orb (2000) state that compassionate care is not simplistically about taking away another person’s pain or suffering but rather entering into that person’s experience so as to share their burden. What impact does this have?

Many nurses talk about feeling guilty if they are not able to carry out an act of care, could this be linked to the above statement?

References:

Dominguez-Gomez, E. & Rutledge, D. N. (2009). Prevalence of Secondary Traumatic Stress Among Emergency Nurses. *Journal of Emergency Nursing*, 35, 199-204

Von Dietze, E & Orb, A. (2000). Compassionate care: a moral dimension of nursing. *Nursing Inquiry*; 7: 166-174.

Participants noted that some instances and difficult experiences stayed with them, remaining in the background:

‘There are always cases that stay with you I think erm I think you store

some and I think there are things that you know, pictures and images that you may still see and remember' (RMN11)

In nursing, there is often the need to go from one difficult situation to another, possibly turning the page over and over again, before returning to it at the end of the day:

'so you've got all these things going on and real horrible things erm you know real significant self harm and traumas that children go through and you're just like 'ok right what's happened now, oh someone's been raped, oh what's happened now oh there's a suicide and you're like ok next thing lets go see' and sometimes we just get a bit hardened to that (mmm) and then when it catches all up on you and you think oh no this is awful, this has happened in one day, it's not very nice' (RMN8)

There was a reflection that nurses can become hardened to this, but also that these things can be 'awful', highlighting the need for self-compassion and self-care to deal with the harsh realities of work. Hence, although returning to 'the page' took place to try and make sense of one's emotions, repeated exposure also seemed to be a means of developing resilience or hardiness to difficult experiences within nursing:

'I think that it's kind of a bit like exposure really when you keep on day in day out having all that happen you do get a bit hardened to it and it is really difficult' (RMN8)

However, this approach to coping was not foolproof and a situation could arise when negative emotions were felt to be uncontrollable:

'what happens is all those things build up to the point where you can't shut off from it all erm because you haven't dealt with' (RGN14)

Consequently, repeated exposure could provide the opportunity to psychologically process emotions involved each time a particular situation

occurred through being forced to repeatedly experience it. This then enabled people to manage what was happening rather than it just being stored:

'I think it's the repeated exposure, would be the first time you experience it is quite intense erm I guess it's like psychological processes once you repeat it, it won't be as profound to you and you'll be able to manage it more or be able to understand what is happening as a process' (RMN10)

It was noted that it can be difficult to recall the good things, when focusing on or storing many difficult experiences:

'yes there are some awful things that I remember but then I don't remember all the good things and all the people that we've saved everyday (mmm) and that's really key (yeah) and that's how I balance it up' (RMN11)

This focused on the idea that 'awful' things are easier to remember, or more often get stored on the shelves in our minds, which could be a reason why burnout and negative consequences occur. This highlighted the possible need to process emotions at the time, with self-care and self-compassion being used proactively rather than as a coping mechanism after a negative event has occurred.

Closing off:

The data raised ideas relating to self-preservation, such as closing off and building a wall. These appeared different to self-care and self-compassion because they blocked yet did not manage many of the emotions and processes experienced by nurses. They represent a short-term relief from difficult feelings:

'I've had it when, you know a really tragic death, you've dealt with relatives, you've dealt with the patient, you've dealt with colleagues, you know it's been an absolutely horrendous day and at the end of the day, you put your coat on and you go home (mmm), and you go back to your house, to your children and you're supposed to be 'that's fine', and you come in the next day and nobody mentions it and you carry on' (RGN6)

The above quotation indicated that the organisation and system within which they work encourages an element of closing off and carrying on, thus not providing a stable base. This perhaps highlights the emotional labour concept as discussed in chapter 2, whereby there is a tendency to employ surface acting and adherence to the display rules of the organisation. The impact then might be felt some years later:

'you don't realise until you talk about them that the impact that they had at the time that they could still affect you it must be twenty-five years on'
(RGN14)

The importance of short term coping strategies and not taking *'everything to heart'* (RMN4), separating and moving away from the difficult situation by going *'elsewhere'* (RMN13) was mentioned as a protective measure, and links to *'turning a page'*. This could be viewed as blocking the emotions rather than managing them. Consequently, supervision in managing emotional aspects of nurses' work may be helpful, to enable them to feel psychologically safe; otherwise difficult situations could be stored and problems encountered later on. Closing off was about self-preservation and if this was not in place there was a risk of being overwhelmed by emotions:

'I think we become very good at closing off and not actually dealing with things because it's far easier, yeah, yeah and I think that's just not for nurses but for doctors as well, I think for anybody, anybody in a profession where you deal with things that are really unpleasant at times and whether that's us, the police force, you know the ambulance, you know you learn you actually as a almost as a self-preservation you know, you close, you shut things off' (RGN6)

RGN6 became very upset when talking about the above. She reflected on the fact that giving of the self and focusing too much on our own emotions can lead to an internal fear and anxiety as there is always the expectation to *'get on and see the next patient'*. This indicated a need to be able to close off in order to keep going, and links back to ideas around putting patients first:

'Sometimes I feel like I'm a bit too cut off from it all (right), I guess in order to protect myself and I think I'm always conscious of that when I have students as well, you know I do probably make jokes about things I probably shouldn't joke about in a sense but because I'm, I've sort of learnt to not get emotionally involved in it coz otherwise you'd have nothing left' (RMN3)

'It would give people nightmares erm but it doesn't so I think it becomes, it builds over time erm I think probably at eighteen walking into a mental health unit I was a lot more scared, there was probably a lot more effected by those things but yeah it builds up'. (RMN11)

The danger of being closed off was it could lead to a task orientated approach rather than actively engaging in compassionate care:

'being kind of mentally present with people, emotionally present with people erm that kind of thing and not kind of being so blunted and cut off... people who I think are so cut off from the people they serve that they've stopped serving them as individuals, they're kind of ticking through the motions rather than actually serving people as individuals erm you know and there are reasons why people cut themselves off to it.' (RMN1)

RMN1 had been qualified for 3 years and reflected on the ability of her more experienced colleagues to 'close off', seeing this from a negative perspective of being distanced from their patients. This resonated with the idea of emotional distancing as an unconscious process proposed by Menzies Lyth (1960) and discussed in Chapter 2.

III) Struggling to recognise the need to cope and manage:

Within the data participants acknowledged that at times they struggled to cope and manage the realities of nursing, which transpired as feeling stressed and burning out. There was also a process of being unable to recognise the need to

cope and manage the emotions of caring, which led to over involvement in patient care by offering too much, and then a refusal to engage in initiatives that were being offered to ameliorate the negative aspects of healthcare.

Feeling stressed:

When participants felt stressed, self-care was seen as impossible:

'I mean some staff can get stressed to the point where you know they're (small pause) when you get to a point where, that you're so, you're so severely low and stressed, the idea of self-care just, you can't even think about it, you can't even think about how you're going to survive till tomorrow' (RGN1)

This suggests that the right circumstances are required in order to proceed with self-care. Alternatively, self-care may need to already be in place when managing difficult situations; it may be too hard to invoke when feeling very stressed, resulting in nurses going off sick:

'but I don't think we look after ourselves (right ok) emotionally, erm which is evidenced when you look at the figures, nurses going off sick with stress' (RGN1)

This quotation highlighted that the risks are known but nurses keep going, which raises the question regarding what is blocking self-care and self-compassion from taking place as a proactive, preventative measure? The importance of recognising stress and then acting to prevent further '*slipping*' was mentioned:

'it was really stressful, very very busy work load and I could feel myself getting very stressed and slipping is how I'd call it (slipping ok). Yeah I remember that from you know previously when you feel that you, you actually not coping as well as you might, so and again put in strategies to help myself (ok, and did that help?). It did, yes, you can, you can bring yourself, you can bring yourself back' (RGN7)

Stress, therefore, was often described as being attended to after it had built up rather than people taking a more preemptive approach. Consequently, teaching nurses to look after themselves as well as looking after their patients was seen as important. This suggested the need for balance rather than getting to the point of burnout to legitimise the need for self-care. This resonates back to the idea of putting patients first and if this is completed without consideration for the self, then it could lead to burnout and other negative effects of caring:

'you know it's tragic, you do walk on wards and find nurses who burst into tears when you ask them about things erm and it happens and they're getting themselves so stressed out and we don't, we don't teach them to look after themselves, we don't teach them how to recognise erm when things are going wrong for themselves. We teach them to recognise it in the patients (mmm) but not in themselves or in their colleagues' (RGN2)

'so I think the burnout bit for me is the emotional bit that used to touch me doesn't anymore erm but I'm reasonably happy with that because I think it makes me better in my job' (RMN13)

Offering too much:

The data suggested that nurses can at times give too much of themselves to their patients without keeping anything for themselves:

'because you're giving all of yourself to someone else aren't you' (RGN3)

'they don't keep anything back and you have to keep something back erm because you need it for yourself. And there are patients who will just drink you dry' (RGN4)

The ideas above relate back to the NMC Code for nurses (NMC, 2015), and provide the sense that the self is an exhaustible resource. As a consequence, some participants talked about getting off an 'escalator' in order to care for themselves:

'I suspect you're on the escalator all the time (mmm) erm and it feels like

some people don't get off, they're not looking after themselves erm so it's sort of, how do you offer that care for others if you're not in that space or, well you can, course you can but erm it's got to be limited hasn't it, limited in it's capacity and duration I suppose (mmm)' (RNMH)

Staying on the escalator could put nurses at risk of losing themselves and being unable to offer patients or themselves any compassion. This may lead to compassion fatigue and burnout.

Burning out:

Many participants spoke of seeing other nurses 'burning out' or being on the edge of this, highlighting a need to self-care alongside caring for others:

'I can think of occasions when people have not looked after themselves, not you know had, gone all out to do everything they can on the ward and have just completely burnt themselves out and have just got to the stage where they've gone on long term sick' (RGN2)

'you get a lot of burnout, coz people haven't come to the understanding that they need to be compassionate for themselves' (RMN5)

If nurses are not looking after themselves then this may lead to 'thinner care', giving a sense that the quality of care is diluted in some way. Hence, nurses seem less able to provide the care they want to or meet their organisation's expectations of quality care:

'it certainly makes the care that they give thinner or so it can seem, coz they're spreading themselves so thin and I think it's valuable that we look after ourselves' (RNMH)

The above appears to occur when the organisational demands are too great or there is a lack of resources, leading nurses to feel that they are unable to attend to their own needs when faced with the growing pressures of the needs of others, resonating with many of the barriers to compassionate care discussed in chapter 2.

Data suggested that nurses have to get to '*burnout point*' or begin to struggle before the idea of caring for the self can be accepted and practiced, reinforcing the idea presented previously of self-care and self-compassion being perceived as reactive rather than preventative strategies:

'you almost get to that burnout point where you think I can't do this anymore and then think 'well why am I doing what I'm doing' (yeah), it's a bit like a light bulb moment, 'aaagh I think I need to do something about this, start looking after myself for a change' (RMN5)

Refusing to engage:

Some trusts had put in place resources for self-care, but these were not always used:

'we just can't work out why, why the nurses aren't engaging in any, any of the things like the self-care that the trust have put on some health things, nobody's engaged in it' (RGN3)

On discussion with nurses regarding this, they felt that many options given to them were not acceptable or feasible, with board games and Zumba at break times being the two mentioned. Yet despite finding these resources unacceptable, there did appear to be a recognition for the importance of caring for the self, with this study helping participants to think about their own wellbeing:

'it's the crux of everything really, if you're not feeling that you can have that self-care and compassion or that you're worthy about what you can contribute then no I don't think you can show it to others, but it isn't until this, the penny's just dropped for me now erm it actually has a really big impact doesn't it' (RGN14)

'I wouldn't say that I'm self-compassionate on a daily basis and I think about it all the time, cause that wouldn't be true but I think, I guess I think about it at a point where I think 'ugh I've actually got to stop and take stock' (ok), and allow myself to do' (RGN7)

Accepting a cycle of compassion:

Participants identified a cycle of compassion and the need to show it inwardly as well as towards their patients, reinforcing the need for a two way process:

'I think if we can't show our self-compassion and look after ourselves then it makes it more difficult to erm look after other people and show that compassion. If you don't care about yourself then how can you care about others I suppose is the term that I would use' (RGN14)

'I think if you can look after yourself well then you're more likely to look after others well but then saying that I'm kind of saying that I don't think I look after myself all that well and yet I feel I can be compassionate so I think there is a link coz I think, I suppose there has to be a link. I think it would be a cycle almost' (RMN11)

'I think if you can't be gentle with yourself then can you really be gentle with other people and I mean gentle in a generalized way of caring for myself, looking after myself, knowing what's important to me' (RGN10)

By caring for the self there was the suggestion that nurses were more able to care for others and had the capacity for a higher level of engagement within that care:

'I think when you've got that self-compassion and that self-care, when you're looking after yourself, you are in a better place to give that care, your whole demeanor is more relaxed and more giving when you're looking after yourself. When you're not looking after yourself you can get in such a state that actually that care you're giving, you miss out on that because of not thinking (right) rather than anything else' (RGN2)

However, it can take time to realise the need to be compassionate towards the self. Taking time to recognise the connection appears to be about reaching breaking point before it is accepted, thus legitimising the need:

'I think compassionate care giving is always there but I think the link

between you being compassionate towards yourself takes a while to erm, for you to realize that you need to be compassionate towards yourself as well' (RMN5)

Alongside the notion of requiring time to make this connection, there also appeared the need to be spurred into action, resonating with the idea of active engagement:

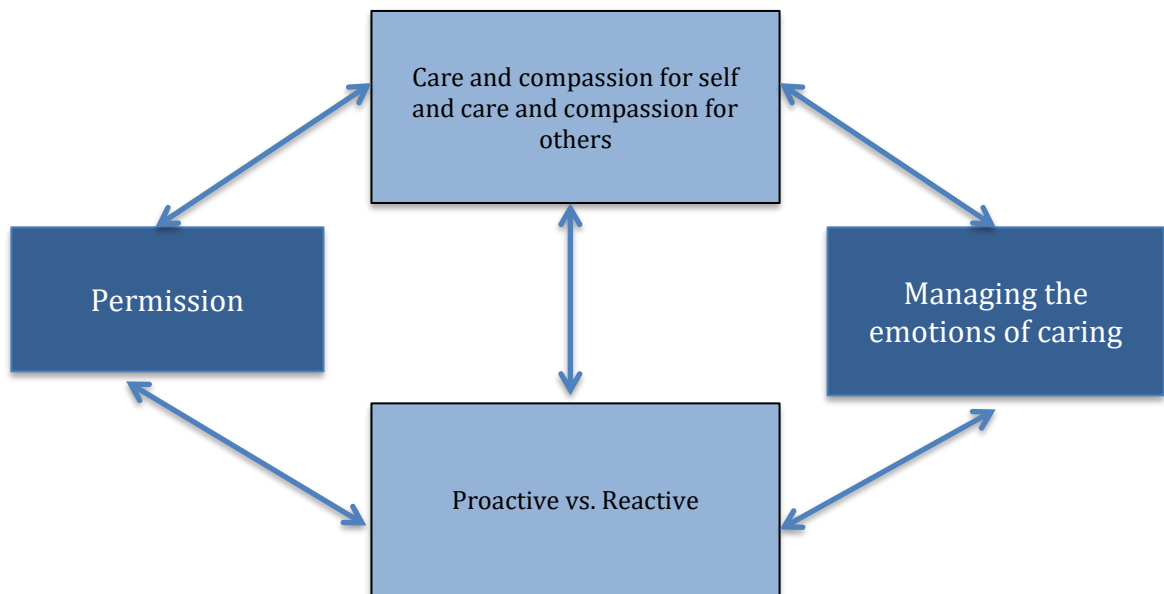
'I think being able to look after yourself, being insightful of what, how you're coping with stuff and how resilient you're feeling at the time erm and when you're not feeling that great you need to help yourself because you can't really help anyone else until you've done that I think' (RMN8)

Summary:

Participants stated that they wanted and needed to care for others, in order to gain from caring, and to feel valued through providing compassionate care. There was recognition that patients come first, instilled through nursing guidance and the expectations of the organisation and individuals themselves. Participants acknowledged that nursing can be difficult, with a need to develop coping strategies in order to manage this, including 'turning a page', becoming hardened through repeated exposure or closing off. There was the idea that nurses are viewed as a resource rather than as human beings, who can become exhausted when overwhelmed or placed under pressure, with burnout often occurring when there is an inability to cope. Self-care and self-compassion may be viewed as reactive coping strategies rather than preventative and as a part of overall wellbeing. Participants stated that some measures are in place for the wellbeing of staff, but these are often viewed as unacceptable, causing a refusal to engage. If participants were overwhelmed, burnt out or unable to apply self-care or self-compassion, there was a risk of 'thinner care'. Figure 6 depicts the idea that in order to manage the emotions of caring, an element of permission to be self-caring and self-compassionate was required. However, balancing compassion towards the self and others was called for, as was an awareness of whether self-care and self-compassion were being used proactively in order to cope with negative side effects of nursing, or reactively, with both self-care and self-

compassion only becoming accessible and permissible when nurses were already struggling.

Figure 6: Managing the emotions of caring



4.7: Core Concept: Needing permission to self-care and be self-compassionate

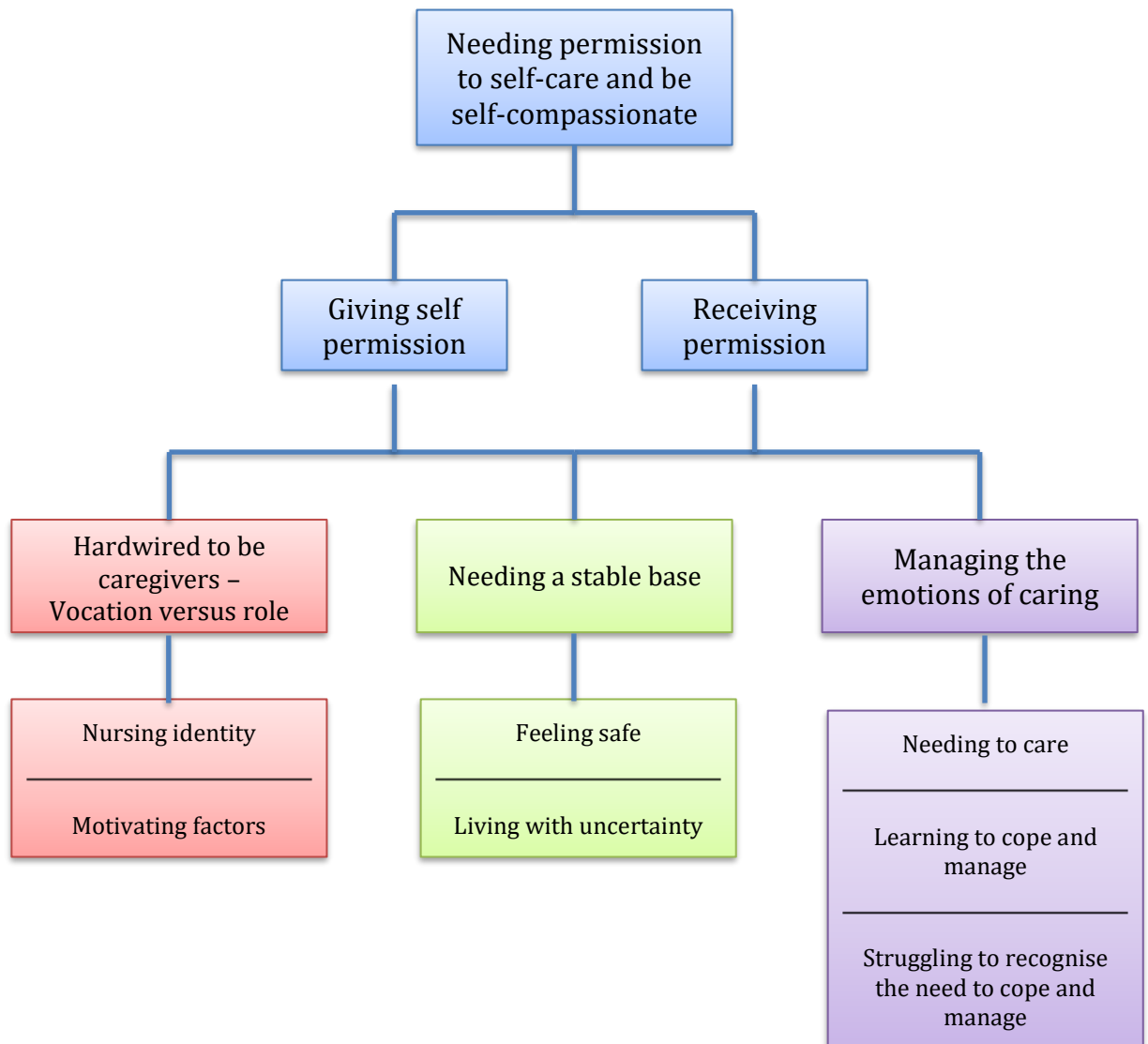
Throughout the previous sections and from exploring the data, a core concept regarding the need for permission in order to self-care and be self-compassionate was developed. The following section will illustrate why this core concept underpins and is at the centre of the final framework. Table 22 shows the coding process for the core concept:

Table 22: Core Concept: Needing permission to self-care and be self-compassionate

Core Concept	
Needing permission to self-care and be self-compassionate	
Core Categories	
Giving self permission	Receiving Permission
Codes	
Taking ownership	Making and having time
‘Failing rather than a need’	Organisation and culture
Understanding and offering self-compassion	Having permission at home and work
Acknowledging and permitting humanity	
Recognising experience	

As this section discusses the core concept and how this relates to the previous concepts within this chapter, it is important to illustrate how the core concept was derived. Figure 7 depicts how the concepts and categories discussed already underpinned the final conceptual framework:

Figure 7: Concepts and categories, which shaped the final conceptual framework



The data, processes and constructs within the three previously discussed concepts highlighted many enablers and barriers to giving self permission and receiving permission in order to self-care and be self-compassionate. The data and subsequent theoretical analysis demonstrated this to be a complex process but an important one in order that nurses feel permitted to care for themselves.

I) Giving self permission:

There was a sense that individuals felt an element of needing to give the self permission to engage in self-care and self-compassion:

'but self-care should be driven by the self I suppose by definition'
(RNMH)

This section considers how permission may be given to the self by looking at the need to take ownership for one's own wellbeing, the ability to prioritise the self, the fact that self-compassion is often seen as a failing rather than a need, understanding self-care and self-compassion and being able to offer it to the self, and acknowledging humanity.

Taking ownership:

Individual responsibility was seen as important in maintaining well-being and self-care:

'I get a sense that it's more the individual's responsibility to seek out that support in order for them to maintain their own wellbeing and self-care' (RMN2)

It may, therefore, follow that people are blamed if they are not perceived to be taking on this duty:

'I've always been very very strict with myself that I don't take it home, so I won't, I won't, if I am back logged I'll go to my supervisor, my manager and I'll say this is happening. I won't take it home and start doing it at home. I feel that's erm, you're hiding an issue then' (RNMH)

This suggested the importance, for some, of finding a balance between their nursing role and their home life. In this example, participant RNMH had no issue with giving himself the permission to be self-caring and self-compassionate in

order to maintain a stable base at home. However, for others, knowing about this and doing it were seen as two different issues:

'you know what we're nurses we know, what we need to do with our lifestyle. Whether we choose to or not is another matter' (RGN1)

'sometimes you just get so involved in everything else that you're doing that you don't look after yourself' (RGN2)

RNMH identified with nursing as a role rather than a vocation, possibly leading to an ease of separation from taking work home.

'Failing rather than a need':

One of the barriers to taking ownership and accepting the need for self-compassion appeared to do with how self-compassion is often perceived. Self-compassion could be viewed as a weakness and as potentially problematic:

'I think as a profession in general we are very very bad at giving ourselves permission to look after ourselves erm and it has, I was gonna say in the past but even now it is seen as a weakness erm, which is very sad... you are expected to push yourself to do things erm and I think it is about giving people permission to, just to look after themselves' (RGN2)

Participant RGN6 states that *'getting on with it'* was easier to bear than *'being too nice to yourself'* and acknowledging when things are difficult, suggesting that self-compassion was too difficult. In this respect, guilt or embarrassment over self-care were identified, with self-care and self-compassion not seen as fitting into a perception of nursing. However, RMN13 did offer an opposing viewpoint:

'I think your weakness is by not being compassionate to yourself really, it's about, has that impact on you in terms of do you think you've got to have all the answers in that respect, erm have you got to cope with everything erm that's really unhelpful because you've got to be able to say at times I'm human, you know I can't cope with this, I don't know

everything. If you haven't got that permission that's a tough place to be'.
(RMN13)

RMN13 reflected during the interview that he had entered nursing later in life and he felt his life experience had helped him in his role. This may account for his increased awareness of the need for self-compassion and recognition of common humanity. It emphasises that permission for self-care and self-compassion need embedding within nursing culture, with their strengths emphasised, in order to move away from them being viewed as problematic. This seems a possibility given that positive impact of self-care and self-compassion were noted within the data:

'if you're kind to yourself and sympathetic and warm to yourself then I think you will transfer that on to people because you'll feel better about yourself...so I do think it would really have a positive impact on patient care, definitely' (DQ1)

Understanding and offering self-compassion:

As self-compassion, in particular, was more difficult to define for participants, there appeared to be a need for more understanding of this concept and when it would be useful:

'I do think nursing in general erm finds it difficult in terms of self-care and self-compassion... it's not till the point where it gets, where they feel they are having difficulty that they then feel forced almost to have to look at self-compassion (ok) and give themselves permission to do that'
(RMN6)

This includes identifying the need to be self-compassionate and kind to yourself as a positive skill that could enhance patient care:

'if you're not looking after yourself I think you are erm, you're always going to find it difficult to look after others, if you don't it comes back to that notion of being, of being more self-aware (mmm) erm and being able

to offer yourself a break or take yourself off the hook or allow yourself a certain amount of mental freedom' (RNMH)

Taking this a stage further, allowing self-compassion for yourself and for others to be valued:

'the self-compassion it has to be allowed, you have to allow it, you're allowing yourself to feel it, but you also have to hope that your managers, your colleagues have room for that as well, have room for you to feel it, recognise that they need it too' (RGN4)

They also talked about the use of humour to avoid becoming emotionally involved. Humour has been previously raised as a means of coping with difficult situations, but this appeared to be used more as a means of cutting the self off from difficult emotions, linking back to closing off. However, it could also be a form of self-compassion by recognising the need for a different viewpoint and being able to view situations in a lighter way:

'with humour, that's always been the number one thing for myself, probably inappropriate at times erm but I also use it with my nursing staff and colleagues as well...where humour is used an awful lot to cope with things' (RMN13)

'Self-compassion, I suppose it is about, erm for me it's about recognising that the job that we do at times can be overwhelming and can be really stressful and we do hear and see and experience really distressing stuff. It's about giving myself permission to switch off from that, so to hear it, to see it, to be able to respond to it and to be able to provide treatment or care or compassion whatever to that person at that time but when I go home giving myself permission to be able to switch off from that (ok). It is about looking after myself physically, it is about protecting, trying to protect myself when I'm in work to some of those really distressing things' (RMN6)

It appeared that there was an understanding that being able to be self-compassionate is a skill and, that if learnt had the potential extremely protective and beneficial; hence, rather than being seen as a soft skill, it has power and can transform experiences of caregiving. The data showed that part of this understanding and acceptance of the need for self-compassion came down to the idea of accepting that nurses are human beings. There also appeared a need to understand the meaning and potential rewards of self-compassion as an important stage in allowing permission.

Acknowledging and permitting humanity:

It was acknowledged that nurses are human beings who can make mistakes. This can be a difficult view to hold as we have already seen a nurse's ideal around prioritising and meeting the needs of others. Accepting that nurses are human, who do make mistakes, can cause a questioning of professional identity, which in turn may threaten their stable base:

'working out erm what it is that causes you to de-stable, or become de-stabilised erm and trying to set those things right (yeah) so again I think it's about that self regard and sort of being aware of your limits and then seeking support when it's necessary...I think we're sometimes expected to be quite bulletproof and immune to these things...' (RNMH)

Making mistakes, or being affected by difficult events, can lead to self-blame, so even when acknowledging one's humanity, there is still a tendency to 'carry' that sense of responsibility:

'I think being kind to yourself and I think sometimes particularly in this role we can be quite hard on ourselves erm it's quite demanding erm and you know like you said we're only human but we tend to carry that sense of responsibility home with us' (RMN2)

There is a need for balance, to acknowledge humanity and to show emotions, whilst maintaining that 'professional status':

'we have to maintain a professional status I totally get that but actually we're only human and if something very very difficult and emotive is happening obviously you can't lose it and be in floods of tears...but I think it's perfectly acceptable to show that you're feeling that' (RGN14)

This fits with the ideas explored in Chapter 2 relating to emotional labour and the notions of surface and deep acting. If nurses are able to give themselves permission to be self-caring and self-compassionate in the face of emotional work then they are more likely to manage some of the more difficult aspects of nursing. Doing this will entail acknowledging their own humanity and fallibility and highlighting that it is ok to not be *'immune'* or *'bulletproof'*.

Recognising experience:

There was an awareness of position and experience, with participants stating that as nurses became older, an element of self-preservation comes in, suggesting a need and willingness to begin to care for the self by giving permission to the self to do so:

'as you get further along the line and you are more experienced, you do, I know I keep mentioning it, but you do give, give yourself permission to take a step back...perhaps in previous years you just go off on a treadmill, but it is much better now' (RGN7)

The importance of looking after the self came through, with recognition of the need to prioritise the self:

'I would say as the jobs gone on it's not been harder to look after me, it's become more important looking after me if you like' (RMN13)

Some participants found this ability to look after the self had transpired due to the knowledge and recognition of warning signs:

'I do have the ability to look after myself err I think because, maybe because of how I, what I'd gone through in the past, erm you kind of start to recognise warning signs' (RGN2)

Or the sense of becoming hardened to distress and difficult experiences through repeated exposure:

'I think I've just become a bit more hardened as I've got older (laughs), realised that you can't get that upset over everything, coz you'd just have a breakdown...you sort of end up being a bit of a rhino, it's yeah. There's certain things that do get to you there always are aren't there but they're not like they were when you first walked out of uni onto the wards and 'oh my god', (laughs), 'how do I cope with all this stuff' (RMN3)

This resonated with the previous section, in managing emotions through repeated experience and therefore developing a thick skin, like a '*rhino*'.

II) Receiving permission:

Due to many of the barriers to self-care and self-compassion, whether they be internal (e.g. nursing identity and character), or more external (e.g. the environment, the lack of stable base and the targets related to care-giving expected by organisations), formal permission from another in attending to their needs was expressed by participants. They mentioned the importance of formal and informal permission from others to be able to challenge, to be able to go off sick, and to lessen the guilt of having to be away from work. This suggested a need to relinquish responsibility in order to feel less guilty by having the decision taken out of their hands. However, there was a sense that this was process and policy driven, which may not be flexible enough to respond to varying professional situations:

'there are processes in place now to manage people's sickness but the humanity within that's gone' (RMN12)

Written formal written permission, in particular, was raised as a means of fostering self-care and self-compassion among nurses:

'but there's nothing on paper, giving you the right (ok), you know to that compassionate care for yourself' (RGN5)

It is interesting from this point of view to establish whether caring for the self is seen to be a right, a responsibility or a luxury.

Making and having time:

A manageable workload was seen as an unachievable ideal:

'just telling myself that it's ok to switch off....it's back to permission, you know it's that self-permission isn't it....what would help that permission, a manageable workload and I know that's not gonna happen, probably not in my lifetime' (RGN12)

There was a sense of sadness and disconnect as participants contrasted the need for permission and the virtue of self-compassion with the realities of practice and the environment within which they worked. Time was not always available to care for self, alongside a lack of permission. This appeared to suggest a link between being provided with time as a means of being given permission:

'I think if anything you get worse about caring for yourself (ok), and I think that's partly because you're not given the time to do that, and you're not given the, you're not given the permission I don't think, I don't think you're given the permission within, within the profession. I don't think we're given the permission to actually say 'I need time out from this, I need to walk away from this, I need to look after me now' (RGN6)

Returning to the idea that compassion is seen as a failing and therefore sits further down a nurse's list of priorities, external permission may be required to raise the profile of self-care and self-compassion. However, the current healthcare structure may not support this:

'part of me says that we do it ourselves and I think we do, however that said clearly everybody's work hours, you know the matron's work hours are always eight till four and yet there will be things put in your diary at half past four and you're expected to be at it, so part of it is an expectation from elsewhere' (RGN2)

Organisation and culture:

Within organisations there was a need for acknowledgement and enforcement of the permission to self-care:

'breaks should be enforced I think. I mean they're not; it's taken for granted that you'll work through your break and that's down to staffing levels (ok), and drinks. I mean I have been told recently that you're not allowed a drink at the, at the nurses station (right). Why on earth not?' (RGN3)

'On the wards I don't think, although you're told that you've got to have a break, I don't think the facilities are made for you to have a break, you get told 'you've got to make sure you have a break, you can't have time owing, it's your responsibility' (RMN4)

As the above quotations imply formal permission was even required for basic human needs such as having a drink or taking a break. This may be in response to the assumption that nurses just *'plough on'*, coping with whatever is thrown at them:

'nurses in particular have this thing that you plough on, you know 'what are you upset for', you plough on (yeah) and I do have concerns when the quest for personal resilience and you know sort of ends up looking like 'well each person for themselves', (mmm) erm because I'm not sure that, that is sufficient. I think organisations do and should have a duty to take responsibility for staff' (RMN1)

This highlighted the need for an organisation as a whole to take responsibility for staff, which may only occur if it can be shown to have a direct, positive impact on patient care:

'I think they would only value it if they thought that it would have an impact on perhaps effectiveness of work and quality standards and patient care not necessarily for the impact on the individual I don't think but I could be wrong' (DQ1)

'I think they do expect you to look after yourself, and but in order to be good to do the job well, to care for people well (ok), but I don't think they'd like that to, what's the right word, to overtake, so that that would become a priority within you, at the risk of fulfilling your role properly (ok). I don't think that would be a top priority' (RGN7)

There was an acknowledgement that self-care and self-compassion may be recognised within organisations, but there was a need to focus on how this then filters down and how it is implemented:

'whilst the trust might have statements about self-care, they might have statements, policies, procedures around things like supervision, appraisal, compassion towards their nursing staff, it's actually individuals then that implement that' (RMN6)

'it can't just be about you as an individual having to take responsibility, yes of course we've all got to look after ourselves, we've all got responsibility for our own health and wellbeing but I think as an organisation we work for we're meant to be a caring organisation, that says it all to me. If you can't care for your staff who can you care for' (RMN11)

Likewise, self-care and self-compassion needed to be embedded within nursing culture and endorsed by the wider workplace to be effective:

'You see the trend in management is to say 'ahh it's the responsibility of everybody, everybody's responsibility, we're all in it together' (laughs), and yes there are individual responsibilities erm I don't doubt that and clearly individuals respond differently and you can see that in working life and some people will fall at the end of the parameter when they're really not taking basic steps to take care of themselves for sure, but I do think that leaders need to have some kind of focus on staff, where staff welfare sits' (RMN1)

This suggests a layered approach of self-care and self-compassion; if one layer is unable to put self-care initiatives in place then it makes it difficult for other layers of staff. Hence, scope of responsibility is broad, but it was recognised that the nursing workforce needs to be healthy to deliver quality patient care:

'the people that are on the ground delivering the patient care, are the people that we need to be the fittest, the healthiest in some ways to be able to do, because they're the forth, they are the outward facing erm probably the ones that need that the most' (RMN11)

Having permission at home and work:

A number of participants reflected on having permission at home as well as at work to care for the self, with a sense of 'wellbeing' not changing, but access to and type of resources being different. If unable to self-care at home, this could affect behaviour in the workplace:

'if I'm not looking after myself when I'm not at work in terms, you know being kind to myself outside of work and giving myself time to just chill out and not do anything then I can't, I'm not able to do that in work' (RMN3)

Having clear boundaries and recognising when service to others ended was raised, alongside the idea that limits were not present at home:

'you don't have a trade union or anybody looking down and telling you, or

any sort of mandatory training erm so your personal life is always very different from your professional one.....professional life has got a casing around it, if you like (ok). Obviously there's guidance, there's rules and regulations, there's staff coming from all sides to erm, you know expectations that you bring, and behave in a certain way. You've got the NMC code to adhere to' (RGN4)

For this participant 'professional casing' was protective, however this was not a viewpoint shared by everyone. This participant had identified a decreased affinity with nursing and had stated that it was not her chosen career pathway.

Participants reflected that a combination of factors could make self-care and self-compassion difficult within both the home and work environment:

'I don't think there are any specific barriers erm but I think a combination of you know personality, lifestyle, habit, you know whatever and it means that I don't always' (RMN1)

Individuals themselves were sometimes the barrier; if insight is there as to the fact that they are not 'ok', this should be disclosed in order to seek help:

'you yourself are a bit of a barrier, because you should be able to say actually 'I'm not ok'...but very rarely you do, you just get on with it' (RGN7)

Again, this reinforces the idea that self-care and self-compassion tend to come about when reaching crisis point rather than as a protective and proactive mechanism. The idea of embedding self-compassion as a 'philosophical bedrock' was proposed:

'I do feel that if we could somehow embed within nursing some degree of self-analysis or some philosophical kind of bedrock about who we are and why we do what we do it could lead us to be more compassionate towards ourselves and others' (RNMH)

This supports the idea of a proactive standpoint of embedding the ideas of self-care and self-compassion early on in nursing as a proactive approach to the difficulties of the job, and may help when thinking about permission to care for the self both within the home and work environments.

4.8 - The Conceptual Framework: Needing permission

The need for permission appeared to be central in order for participants to feel able to be self-caring and self-compassionate. For some it was about giving themselves permission and for others it was about receiving permission (i.e. from their manager or more globally from their organisation), or a combination of the two. There was a sense that if self-care and self-compassion were more understood and embedded within nursing education and the workplace culture, this would serve as a form of permission. There was also the idea that if a nurse's wellbeing and need to care for the self was acknowledged by society, the public and patients, this would aid nurses to feel like they had been given permission.

Data showed a number of ways in which permission can be influential. The section 'Hardwired to be caregivers' – vocation versus role, noted the impact of nursing identity and the sense of self within that, with this often blurring whether self-care and self-compassion were viewed as acceptable within the role of a nurse when patient care is priority. A small proportion of the data suggested that if nursing is viewed as a role rather than a vocation, then the ability to care for the self is more accessible and acceptable. However, due to the fluid nature of identity within this dataset, this can change over time. The notion of 'Hardwired' refers to the innate need to nurse, the motivations to enter nursing and whether this is present or not and how this fits with identity, taking the self and professional role into account.

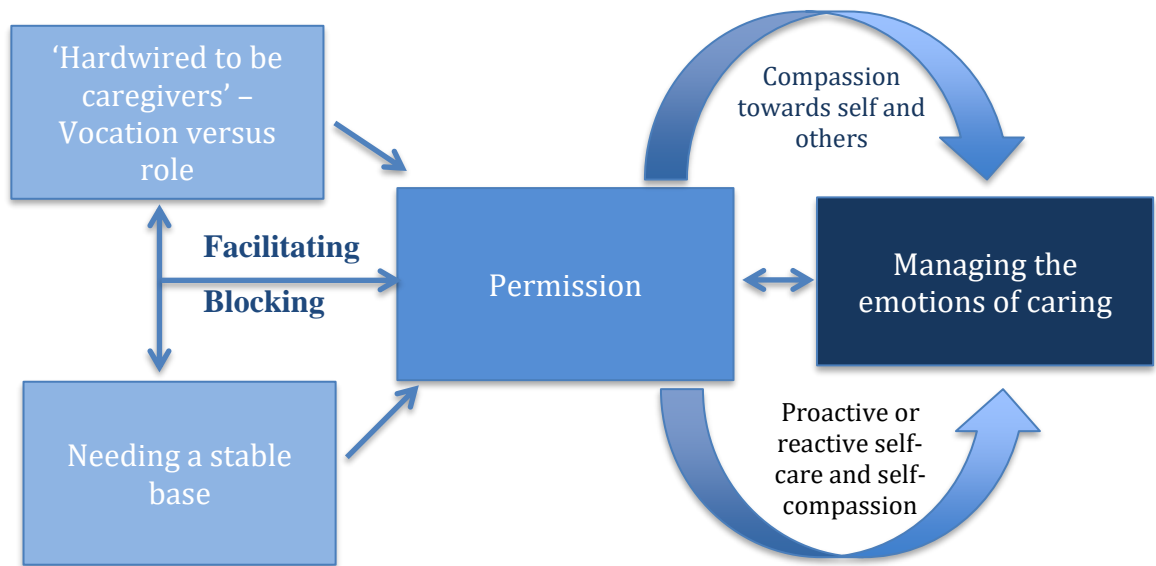
The need for a stable base within a culture of change was also explored, with participants identifying that if they feel safe, secure and stable, whether it comes from the self or the environment in which they work, then permission to care for the self appeared to be present. However, participants acknowledged that if they were feeling destabilised, uncertain or unsafe then they were less likely to care for themselves and more likely to experience negative emotions, with this

impacting on their overall wellbeing and impacting upon their ability to provide compassionate care. Therefore, both of these sections encompassed facilitating and blocking factors with regard to enabling permission.

Being able to have permission, and being able to be self-caring and self-compassionate, appeared from the data to link to managing the emotions of caring that could affect compassionate care giving. There was a sense that in order to care for others you must care for yourself; however, this was not seen as an easy process. Self-care and self-compassion tended to be viewed as coping strategies that were only used when participants were ‘close to the edge’, ‘burning out’ or ‘becoming overwhelmed’ with caring. Yet participants acknowledged that self-care and self-compassion could be used more proactively by allowing the time to reflect on their needs, accepting their humanity, being kind to themselves and managing the emotions of caring. Data suggested that if participants were able to self-care and be self-compassionate, this would positively impact their own wellbeing but also prevent them from delivering ‘thinner’ care, and instead offer the compassionate care that they wanted to provide.

Figure 8 depicts the final conceptual framework and theory constructed through the process of data analysis as outlined in Chapter 3 and supporting appendices. The framework depicts permission as central and as being influenced by the concepts relating to ‘Hardwired to be caregivers’ – vocation versus role and needing a stable base, with these presenting many facilitators and barriers to nurses feeling permitted to care for themselves. Permission is needed if nurses are to care for themselves and to manage the emotions of caring and providing compassionate care. There appears a balance and need for compassion towards the self and others, with much of the data suggesting that nurses may be aware of this need, but are unable to engage in this process due to the barriers facing them. Self-care and self-compassion seem to come online reactively, when difficult situations are experienced, burnout occurs or ill health occurs rather than being used proactively to prevent this and more effectively manage the emotions of caring.

Figure 8: The conceptual framework - Needing Permission



4.9 – Summary

Data analysis was conducted in line with the Constructivist Grounded Theory approach suggested by Charmaz (2014). It resulted in the emergence of three concepts: 1) 'Hardwired to be caregivers' – Vocation versus role 2) Needing a stable base and; 3) Managing the emotions of caring. All three concepts linked to the core concept; needing permission to self-care and be self-compassionate. Findings suggested that nurses require permission to care for themselves, which was facilitated or blocked by a number of factors. These ideas will be expanded upon in Chapter 5, which discusses the study findings and conceptual framework in relation to the study's aims, taking into account the broader literature, its contribution to knowledge and outlining implications for nursing education, policy and practice.

CHAPTER 5

DISCUSSION

Part one

Discussion of the study findings

5.1 – Introduction

The aim of the study was to explore the experience of self-care and self-compassion in nursing and to look at how these experiences related to compassionate care giving. The following two questions guided the study throughout:

- What are nurses' experiences of self-care and self-compassion?
- How do these experiences relate to compassionate care giving?

It is important for the context of this study and thesis that I triangulate my presented theory against existing concepts and thus critically discuss its utility. The previous chapter presented the key findings in the form of three concepts, a core concept and a final conceptual framework, 'Needing permission' (See figure 8, chapter 4). A discussion of the findings is presented in the following subsections, placing them within the existing literature base. The sections acknowledge key points and theories raised by participants, the co-construction of ideas between the participant (through discussion) and I (through the process of reflexivity). Their relation and place within the final conceptual framework 'Needing permission' are also explored. These findings are placed within the broader literature:

5.2 – The presented theory of permission

5.3 – The need for a sound identity

5.4 – Understanding and engaging with the key concepts

5.5 – Needing positive perception

5.6 – Education and early key messages

5.7 – The environment and the leader

5.8 – Proactive or reactive engagement

5.9– Part one summary

5.2 – The presented theory of permission

The need for permission appeared central to this study and the final conceptual framework, with participants recognising it was required in order to offer themselves care and compassion. Permission took two forms. Firstly, from the self, indicating the need for ownership and an acceptance of responsibility for their own wellbeing. Secondly, from others, which placed the focus on the organisation, the leaders and appeared a more formal process, thereby legitimising engagement in self-care and self-compassion. A number of factors facilitated or acted as barriers to the need for permission being recognised, received or accepted. However, permission appeared important when considering the management of emotions when caring for others.

There was no literature other than a narrative piece in midwifery (Hirsch, 2014) looking at permission related to self-care and self-compassion in healthcare. A number of websites (domestic violence⁷, self-care blogs⁸) have identified a need for permission in order to care for the self, with one of them even providing a permission slip. Furthermore, a questionnaire for carers of people with Alzheimer's⁹ referred to the permission to care for the self. However, nothing rooted in healthcare or nursing could be found specifically on this topic of permission. Therefore, findings from this PhD make a novel contribution to the literature.

Within the findings there appeared a need to give the self the permission to engage in both self-care and self-compassionate activities. This encompassed the need to take ownership for the self. However, this risked blaming individuals if this was not done, even though there appeared to be barriers external to the self that prevented such action from being taken. For example, the idea that self-care and self-compassion were viewed as negative existed within the findings; it could

⁷ <http://www.seethetriumph.org/blog/giving-yourself-permission-to-care-for-you-self-care-series-introduction>

⁸ <http://www.discoveringyourawesome.com/giving-yourself-permission-making-self-care-a-priority/>

⁹ <http://www.alz.org/ct/documents/b6.pdf>

be seen as a weakness, or feeling guilty/embarrassed at caring for the self. This resonated with the narrative piece by Mills et al (2014) who questioned whether self-compassion was selfish or essential, and the study by Campion and Glover (2016) who found self-compassion generates feelings of guilt and vulnerability. Hence, for permission to become more accepted within nursing, it possibly needs to be embedded within the nursing culture, so it is viewed in a positive way. This may take time to cultivate and nurture, which is a consideration also highlighted upon within the existing self-compassion literature.

Permission was noted as a means of taking ownership and responsibility, by being viewed as more acceptable and accessible. Ownership did not appear possible if permission was not granted, as the expectation remained that the patient's needs are always prioritised. Gantz's (1990) review on the concept of self-care suggested the importance of individual ownership. Likewise, Roberts (1999) noted the idea of personal responsibility within the profession. Therefore, the literature goes some way to support these ideas as important; it is now necessary to explore and discuss what may block permission and personal ownership and responsibility from taking place.

How nurses treat themselves may begin to explain these barriers. The idea that participants found it easier to be harder on the self as opposed to self-compassionate was present within the findings, resonating with research by Pauley and McPherson (2010) and Gilbert et al (2011). This could link to the literature on the historical influences of nursing and the notion of only focusing on the patient, without the nurses' emotions interfering in this (Landale, 1893; Nightingale, 1898; Houghton, 1938; Bradshaw, 2011). This focus on others appeared to fit with society's construction of nursing and the fact that the patient comes first (nursing others), (Takase et al 2002; Errasti-Ibarrondo et al, 2012). This perhaps made self-caring and self-compassion less acceptable in the eyes of the nurse, due to public perception and society's interpretation of being a nurse. My findings supported the notion of nurses finding it easier to care for others as opposed to themselves and began to explore why this may be the case; identity and stability appeared to be key concepts when considering the barriers and facilitators, and highlighting that if permission were granted then accessibility of

caring for the self could occur. This indicates how nursing culture could be influenced to enable nurses to care for themselves alongside their patients.

Patient as focus

The literature often focused on instilling self-care within patients (Orem, 1981, 1985; Webber et al, 2013; Richards, 2013; Davidhizar, 1993) rather than considering such activity for healthcare staff. These ideas, alongside nursing guidance, such as 'The Code' (NMC, 2015), appeared to have led to the belief that a nurse's self-care and wellbeing were not priorities. These ideas ran alongside the verbalised need to care for others, which many of the participants reflected upon, identifying this as the primary reason for entry in to nursing. Participants showed a lack of awareness of how ignoring their own needs may jeopardise their primary aim of caring for others, but acknowledged a frustration that they were not able or not permitted to care for themselves alongside caring for their patients. This point has not been previously raised within the existing literature. The literature instead highlighted the need to approach one's own vulnerability alongside that of patients (Gustin & Wagner, 2013), yet offered little insight as to how to approach this. Orem's (1981) model of self-care reported the need to empower patients to care for themselves; this model could also be used to empower nurses to take control of their own self-care, with permission providing a possible means of accessing this.

Gratification from caring

Participants acknowledged that they gained something from caring for others, including self-worth and feeling valued. This mirrors literature relating to compassion satisfaction and receiving gratification from care giving (Simon et al, 2005; Utrainen & Kyngas, 2009; Hooper et al, 2010; Beck, 2011; Rossi et al, 2012; Li et al, 2014). Bradbury-Jones et al (2011) identified that feeling valued for nursing students and nurses led to empowerment, which affected care giving by fostering of a sense of control and self efficacy. Hagerty et al (1992) also proposed feeling valued and having a sense of belonging as a vital mental health concept within nursing, with importance placed on feeling an integral part of a system or environment. This links to the conceptual framework outlined in chapter 4 and the need for a stable base and feeling safe within a work

environment. Participants viewed compassion satisfaction as a form of self-care, with self-worth being established through the response of others. However, it was not self-generated so could be limited to when more positive aspects of care giving occurred (e.g. receiving positive feedback from a patient or a relative).

Being permitted by another

Relating to the above ideas, there was a strong need for permission to be gained from others. This included permission from colleagues, managers or leaders, the public and the organisation. However, this often appeared juxtaposed to the expectation that nurses just 'plough on'. This could be seen as relinquishing responsibility by being given permission, linking back to nurses' sense of guilt and embarrassment, and self-compassion being viewed as a weakness. Viewing self-compassion as a failing may mean nurses automatically and possibly unconsciously push it down their list of priorities. Hence, external permission may be required in order to raise the profile of self-care and self-compassion. However, at present the structure and the instability that nurses are experiencing is not supportive of this, which caused sadness and disconnect as interviewees acknowledged the virtues of self-compassion alongside the realities of practice. Crawford et al (2013) examined the language of compassion with acute mental health practitioners through corpus assisted discourse analysis. They found minimal description of compassion related behaviours despite it being the topic under study; instead they found emotional distancing and a focus on working in a production line mentality with increasing time pressures and demands. This led to a '*clear difficulty in articulating compassion and a displacement of a compassionate mentality by the threat stress clearly linked to a production-line approach to care delivery*' (p725). The utility of the conceptual framework for this study is supported by this quotation. It highlights that if nurses learn to accept permission to care for themselves, or if permission is received from another, then self-care and self-compassion may be viewed as acceptable, thus embedding the notion within the wider nursing culture.

5.3 – The need for a sound identity

Findings of this study postulated that identity and how a nurse self-identifies impacts upon the perceived acceptability of concepts described in chapter 4 and whether a nurse is able to self-permit or accept permission from another to care for themselves. The next section explores these ideas.

Perception of the self

The findings suggested numerous ideas relating to I as me and I as a professional, with the idea of the identity of the nurse being a key area when thinking about permission and its utility.

This study revealed two different schools of thought for the participants; nursing as self and nursing as a role. However, findings did not provide a clear classification within the data, but rather a more nuanced understanding. Those who felt the former referred to a vocation and a need to care for others from a young age. They proposed that nursing was their whole identity, making reference to ‘a nurse is who I am’, implying a lack of a sense of self outside of that. This resonated with the literature related to nursing as a calling and within that a sense of sacrifice (Nightingale, 1898). Nightingale popularised the idea of nursing as vocational, largely due to the totality of care required and the idea that nursing involved carrying out duties that many others would prefer not to do: *‘if a nurse declines to do these kinds of things (emptying chamber utensils) for her patient, because it is not her business, I should say that nursing was not her calling’* (p22). Raatikainen (1997) defined a calling as: *‘a deep desire to devote oneself to serving people according to the high values of the task or profession’* (p1111). She conducted a quantitative questionnaire study (n=179) in Helsinki, to clarify differences between nurses who experienced a calling (n=81) and those who did not (n=95). She concluded that experiencing a calling was a strong resource, forming part of their character and identity, and provided strength in order to care for others. She did not provide any detail of those who did not receive a calling, making it difficult to interpret the results. Nevertheless, her study did show a clear divide between those who considered nursing as their vocation and being called to the profession and those who considered it a role. Possible implications for the ability to care for the self may transpire when there

is a deep-seated calling to care for others compared to identifying with nursing as a role.

Blurring of identities

My findings suggested more of a blurring between vocation and role, and may be due to the qualitative methods used and the ability to capture a more nuanced understanding of the topic. The concepts of self-care and self-compassion may have prompted the participants to start thinking in a less black and white sense, with the consideration of a nursing self and the self outside of this role. Lane (1987) used the term vocation as a synonym for ‘a calling’ and suggested that nurses who possessed a sense of vocation may broaden and enhance the care provided to patients. However, this then could link back to notions of self-sacrifice and becoming overinvolved in care giving, as discussed in chapter 2. Participants who identified solely as a nurse, with a perceived limited sense of self outside of this, hinted that they were able to provide more compassionate care. However, findings also suggested that being unable to see a sense of self outside of nursing precluded self-care and self-compassion, both of which are linked to compassionate care. Participants postulated that viewing nursing as encompassing one’s identity may be a barrier to caring for the self, due to the intrinsic need to care for others.

Rinaldi Carpenter (1989) identified common elements in the experience of a commitment to nursing as altruism, devotion, dedication, caring, being there, trust and loyalty, and suggested a sense of sacrifice for the good of another. This has caused much debate within the literature, giving rise to questions about how altruism is misrepresented with self-sacrifice (Jackson & Borbasi, 2000) and noting the need to disentangle ‘vocation’ away from its identification with altruism and femininity (White, 2002). The findings of this study highlighted that it may not be as simple as holding the idea of a vocation or a professional role and suggested that often there was a blurring of the two. What was clear from the data was that self-care and self-compassion were often more difficult if nurses were so involved in care giving they sacrificed their own needs in favour of constantly prioritising the patient.

The above highlights the complexity of the issue and the need for nurses to construct a clear identity and to be aware of their own needs and how this might ultimately impact upon the compassionate care they wish to provide. This idea caused me to reflect on my own experience, as can be seen in Box 4.

Box 4: Reflection 1

Reflection 1
The findings for my study caused me to reflect on my own ideas around nursing as a vocation; I realised that I had wanted to be a nurse since childhood and held many of the ideas regarding ‘a nurse is who I am’. I reflected on my ability to self-care and be self-compassionate and recognised that these practices had been easier to engage in more recently, suggesting a link to my own experience and awareness of priorities. I am aware that these practices were more difficult when working in inpatient services, often due to the work demands and environmental factors. However, my nursing identity has not changed, although I may have become more boundaried with my time and myself as my career has progressed.

Constructing the nursing identity

The importance of constructing a sound identity within nursing has been highlighted in the literature (Becker et al, 1961; Mackintosh, 2006; Curtis et al, 2012; Maranon & Pera, 2015; Traynor & Buus, 2016). Much of the literature regarding nursing identity has placed a focus on new nurses and the idea that individuals enter training with an idealised view of nursing work, which then most lose due to the realities of current healthcare environments and the behaviours of some experienced nurses (Mackintosh, 2006; Maben et al, 2007). The issue of identity and when it is constructed caused me to reflect on my own personal experience, and can be viewed in Box 5.

Box 5: Reflection 2

Reflection 2
At the age of 17 years I witnessed two close friends being mentally unwell and it was through trying to help them that my interest in mental health was piqued. On reflection this was also an important age for exploration of my own identity and development of my sense of self, with a need to care becoming part of that. I therefore entered nursing with an identity construct around wanting to care for others, although I feel my professional identity was created throughout my nurse training and nursing experience. I also feel that for me, my nursing identity has not been static but rather has continued to be constructed throughout my nursing career.

Johnson et al (2012) noted that many individuals constructed their identities prior to commencing nurse training, but highlighted the importance of the training period in exposing people to the realities of what it is to be a nurse. By exposing the realities of nursing, the importance of self-care and self-compassion could be relayed simultaneously indicating that these concepts could be taught as part of the nursing curriculum and citing their importance in the nursing identity. However, it is important to note that an identity can be created, but to question whether this is completed through nurse training and is nurse training required in developing the ‘nursing identity’. Findings from this study do not answer this question, but rather confirm the need for a sound identity and recognise the importance of how nurse training and early nursing experience shape the sense of self.

An important component to the nursing identity and character within the findings was compassion. Participants tended to suggest that most nurses were innately compassionate, leading them into the profession, with compassion being viewed as part of their self that they were able to express in a work capacity. Some literature supports this view of an innate ability to be compassionate (Tuckett, 1998; Von Dietz & Orb, 2000; Shantz, 2007), and a highly evolved capacity for compassion (de Waal, 2009; Gilbert, 2010). Many participants also felt that compassion could not be taught and was either present or not within the individual. There is much debate within the literature as to whether compassion can be taught (Bray et al, 2014; Muncer et al, 2015; Richardson, 2015). However,

it was acknowledged within my findings and supported by the literature (Firth-Cozens & Cornwell, 2009) that compassion could be increased or reduced dependent on the situations and environments individuals faced. This appeared to apply to the ability to display compassion and resonated with the emotional labour literature (Morris & Feldman, 1996; Huynh et al, 2008; & Sawbridge, 2016). It also resonated with research conducted by Tierney et al (2017) when thinking about organisational defenders and drainers of compassion.

Becoming dehumanised

According to interview data, as calls appeared for patient care to be more person-centred, this often came at a cost to those delivering that care in terms of being dehumanised. A focus on the more technical skills within nursing risked professionals moving away from relational components within the field, resonating with the ideas presented by Bolton (2000) in chapter 2. Menzies Lyth (1960) advised that nurses dehumanise and distance themselves from their patients in order to cope with the difficult emotions of caring. However, findings from my study suggested that dehumanisation was driven more by the organisation rather than as a personal means of coping. This reiterates the aforementioned irony that as there is more of a push at an institutional level for compassion towards patients and care to be person-centred, there seems to be, at the same time, a perceived sense of dehumanising staff delivering that care, whose own needs are being ignored, with the drive to put patients first limiting professionals' access to self-care and self-compassion that could support them in providing compassionate care. A situation is therefore required to balance the humanity of the nurse and being able to show emotions whilst maintaining a professional status. This links back to the identity literature and resonates with the literature relating to emotional labour and ideas around deep acting (Hochschild, 1983; Gross, 1998; Mikolajczak et al, 2007; Holman et al, 2008; Diefendorff et al, 2011).

5. 4 – Understanding and engaging with the key concepts

As part of identity, findings incorporated how nurses understood and engaged with the key concepts under study. It appeared that nurses needed to understand

them if they were to engage with them and feel permitted to use them, however many facilitators and barriers were noted and will be explored next.

Experiencing self-compassion

Despite a number of definitions for self-compassion within the literature (Neff, 2003; Heffernan et al, 2010; & Lindstrom, 2014), the findings suggested that participants found it difficult to define. Many reflected that they had come across the term compassion but had not heard of self-compassion or they felt confused by the term. When given the chance to think about the term and what it might mean to them, many participants used their knowledge of compassion towards their patients and the components of this and then turned it inwards towards the self. Consequently, they often referred to ideas proposed within the self-compassion literature around kindness, self-protection, common humanity and wisdom (Neff, 2003; Leary et al, 2007; Neff et al, 2007; Thompson & Waltz, 2008; Neff & Vonk, 2009; Shepard & Cardon, 2009). The level of understanding appeared to increase during their interviews, as they were able to reflect on self-care and self-compassion.

The link between self-care and self-compassion

One of the participants proposed a need to be self-caring in order to be self-compassionate. However, Sirois et al (2015), in their study on self-compassion, stress and coping in the context of chronic illness, stated that self-compassion was associated with improved self-care, thereby suggesting that self-compassion preceded self-care. It is difficult to ascertain the direction of the link between the two concepts within the context of this study. However, an association appears present, that self-care and self-compassion co-exist, with many suggestions within the findings that self-compassion forms part of self-care. This is supported by a meta-narrative review by Sinclair et al (2017) exploring whether self-compassion can promote healthcare provider wellbeing and compassionate care to others. They concluded that self-compassion as a construct is problematic and instead propose self-compassion as '*a composite of common facets of self-care, healthy self-attitude, and self-awareness rather than a construct in and of itself*' (p1). Within the literature self-care and self-compassion hold separate definitions and it is my understanding and viewpoint that they are separate constructs.

Findings from this study posit that self-care is about looking after the self to avoid becoming unwell, whereas self-compassion appeared to align with treating oneself with kindness and acceptance of one's humanity and fragility. However, both constructs could be linked and hold important features when considered as part of an overall picture of a nurse's wellbeing. The main ideas that linked the two constructs within my findings were an awareness of the self and the emotions that are being experienced and a wish to alleviate the suffering in the self and to feel better.

Needing a better understanding

More generally, self-compassion needed to be better understood, including the benefits of its application. Gilbert et al (2017) focused on the development of compassionate engagement and action scales for the self and others. They recruited participants from three different countries (UK, Portugal & USA), to complete three new measures of compassion competence, specifically focusing on three orientations - compassion for others, compassion from others, and compassion for the self. These orientations resonated with the findings of my study in thinking about care and compassion for patients, caring and being compassionate to each other, and self-care and self-compassion. However, my findings also suggested permission as a means of facilitating or acting as a barrier that may alter and impact the flow of compassion. When looking at compassion to others, Gilbert et al (2017) identified the difference between emotional connection and '*suffering focused compassion*' (p19), versus behaving in helpful ways, with a suggestion of a balance by being skilfully compassionate so as not to become overwhelmed. This was highlighted in the literature focusing on how far a clinician enters into the suffering of another (Nussbaum, 1996; Von Dietz & Orb, 2000). In respect to compassion from others, Gilbert et al (2017) noted that this might be compromised if there are high levels of distrust, resonating with the ideas from my study in needing a stable base. Gilbert et al (2017) also wrote that self-compassion can be difficult to define and measure, adding '*if being sensitive to one's suffering and distress only leads to worry or rumination, this would be unhelpful*' (p20). This chimed with my study as one participant noted that it felt easier to avoid being kind to the self and became distressed when thinking about self-compassion, reinforcing the need to embed the importance of

self-care and self-compassion early in the career of a nurse so these concepts are accepted and permitted as a normal part of professional life.

Accessing compassionate care

Participants had no difficulties in defining what compassionate care meant for them. Human connection seemed central to their understanding, linking to ideas around humanity and the affiliative system proposed by Gilbert (2010). However, this posed the question of how nurses affiliate with unknown people, who potentially do not show gratitude, are demanding, jeopardising their own health or may test an individual's sense of caring. Literature suggests that it may be easier to care for people whom we identify with or perceive as being 'like us', part of unconscious bias (Blair et al, 2011; Teal et al, 2011). Self-compassion may help the acceptance that unconscious bias is part of being human and that if we are aware of our own unconscious biases we can then act on them during interactions. This highlights just one of the challenges nurses face and could add to the argument for nurses to be aware of their own emotions and wellbeing and to be permitted and enabled to care for themselves.

Fox (1990) proposed that compassionate care held a sense of togetherness, citing the importance of a collaborative approach, with Nussbaum (1996) suggesting that providing compassionate care involved the clinician and patient choosing to act together. However, the findings from this study suggested that this might be an illusion, with nurses taking the lead and feeling the pressure of the realities of caring for those who are very unwell or distressed. Existing literature does not aid this, as there appears no consideration of how nurses care for themselves in the compassionate caring relationship; rather suppression of emotion or adoption of a particular persona in order to care for another is described (Mackintosh, 2007). Cozens and Cornwell (2009) focused on a collaborative approach to compassionate care giving and suggested the need to identify both the emotions of the nurse and of the patient to understand both sides in the collaborative relationship. However, Fox (1990) warned that compassionate care did not require nurses to fully immerse themselves in the suffering of others, purely to suffer too. Frank (2004) also advised caution, adding that compassionate care often involved giving more than you had access to. Mylod and Lee (2013) stated

that healthcare providers must organise themselves to anticipate, detect and mitigate a patient's suffering and distress, by offering a framework to look at avoidable and unavoidable suffering. However, it was difficult to establish whether healthcare professionals identified with suffering. This may be due to managing many emotions at once or competing demands. This appears to be a complex issue, balancing the collaborative relationship with how far suffering is entered into, and this may then impact upon the perceived ability to care for the self or receive permission in order to do so.

Many of the participants stated the connection for them was about empathy and being able to put themselves into the shoes of the patient, which links to ideas in the literature around the ability to be empathic (Figley, 1995; Morse et al, 1992; & Reynolds & Scott, 2000). However, findings suggested that nurses go from one task to the next, repeating experiences and therefore not necessarily placing themselves in the shoes of each individual patient but rather having a schematic approach about how each interaction will occur. According to interviewees, this was often used as a protective measure with nurses remaining closed off from the emotions of caring by taking this approach. It is unclear from the findings why this was the case, although there was the suggestion that their own emotions may be too overwhelming or painful or that they would be viewed as weak or vulnerable if they acknowledged their own suffering, causing them to question their professional identity.

Alleviation of suffering

Participants in this study did not explicitly talk about one of the key components of compassionate care in terms of the alleviation of suffering and being active within this process (Dalai Lama, 2001; Gilbert 2010), instead focus was placed on having a connection with the patient in order to attend to their needs. This was a key finding and suggested that placing the patient at the centre made it difficult to expand the sphere of vision, therefore making it risky to look inwards at one's own needs. Again this reinforced the possible importance of permission and being permitted to look inwards and care for the self.

5.5 – Needing positive perception

Findings proposed that in order to turn compassion inwards and to care for themselves, nurses needed to be perceived positively and favourably by others. If nurses felt stable in how they were being viewed they appeared more able to feel permitted to care for themselves.

Public perception

The findings within this study highlighted that nurses live with uncertainty due to the constant change within the NHS, and due to perceptions regarding how nursing is portrayed within the media and regarded by the public following negative healthcare inquiries (CIPOLD, DoH, 2013; Francis, 2013; Bubb, 2014; Kirkup, 2015). The changes discussed within the data focused on service restructuring, poor staffing levels and jobs being at risk, which all have a destabilising effect and ultimately impact on people's ability to be self-caring and self-compassionate.

The perceived shift in public perception of nursing referred to in the findings had rocked some participants' identity and core beliefs. This is an interesting point, relating to the notion of socialisation in term of what makes a nurse and how is a nurse constructed within the minds of different groups, such as the public, other healthcare professions and nurses themselves. The impact of negative health inquiries (Francis, 2013) and associated reports (Health Service Ombudsman, 2011; DoH, 2012; The Patients Association, 2009, 2011, 2012), single out nurses as uncompassionate, with patients said to experience a lack of basic care and compassion. Youngson (2008) identifies an increasing concern regarding failure at a fundamental level with care and compassion, and proposes that '*healthcare professionals who previously enjoyed high status and unquestioning authority now feel beleaguered and threatened*' (p3). There remained a sense of pride at being a nurse but this was affected by the perceptions of others, which could influence how nurses regarded their own needs.

Looking back

There was an element of looking back into the past days of nursing as a means of coping, due to the perception that the ‘past’ was better. There appeared to be no research literature directly on this phenomenon. However, the idea relates to the psychological concept of rosy retrospection (Mitchell & Thompson, 1994), which could highlight a barrier to acceptance of current healthcare initiatives and change. The past was stated as ‘better’ due to services being less business centred, not driven by targets, with a perception that there was a greater focus on care and also being seen favourably within the media and by the public. This highlighted the notion that in the past there was more of a focus on people than processes. When focusing on the business centred approach, the literature described the cost of care over the years (The Kings Fund, 2015), rather than focusing on the impact of this approach within the healthcare setting. The existing literature supported the findings of this study as to the negative impact of the move towards a business led model of care (Leebov & Ersoz, 1991; Duffield et al, 2009).

The next section expands upon perception by exploring how nurses are perceived on entering the profession and the impact thereafter of education and early key messages.

5.6 – Education and early key messages

The right people entering the profession

Some of the participants made reference to ‘the right people’ not always entering the profession. Within nursing educational institutions and healthcare organisations there has been a move towards ‘values based recruitment’ (Health Education England, 2016), with a drive to recruit the ‘right people’ for nursing careers. This suggests many of the ‘vocational’ elements are still being looked for within individuals entering the profession. However, this can often be at odds within the current NHS environment, which places a focus on task completion and targets rather than the relational components of care giving. (Duffield et al, 2009; Valizadeh et al, 2016). This identifies the environment and culture as not permitting.

Feeling equipped

Findings emphasised that historical and current nurse training did not provide tools to prepare individuals to be self-caring or self-compassionate. Many of the participants focused on the emotional impact of nursing, bearing witness to a multitude of difficult experiences, and being unprepared to manage these.

RGN 9 had trained outside of the UK and reflected that she had been taught to adopt a ‘mode’ in nursing. The way this was discussed in the interview suggested that the ‘mode’ was very similar to the vocational elements of nursing already discussed, with there also being a very religious connotation for this particular individual. For her it was about caring for others in order that she gained in the afterlife. Many of the religious elements she discussed fit with the historical context of compassion in nursing in the UK, as explored in chapter 2. Her discussion of ‘the mode’ resonated with work by Mackintosh (2006) and her ideas around adopting a ‘work persona’ in order to cope with the emotional demands of the job. Both the ‘mode’ and the ‘work persona’ appeared to be used as a method of protection against the difficulties associated with nursing. RGN7 spoke of her training again in a country outside of the UK. She reflected that self-care had formed part of this, with a focus on not putting the self at risk. Such a focus does not appear to be present in nurse training in the UK. Literature could not be found to explore this further and highlights a possible area for future study.

Early messages

Participants acknowledged the importance of early role models and the messages received around caring for the self as well as caring for others. I reflected on this notion in Box 6.

Box 6: Reflection 3

Reflection 3
During my nurse training I considered myself to be very lucky that I had a number of mentors who advised me on the importance of being able to show my emotions and reflect on difficult experiences. Yet there were exceptions to this and I did find myself crying in the sluice, as many others had done before me, for fear of being ‘caught crying’. I also acknowledged that for me there had been an element of showing others that I was unaffected. However, I am unsure why this need was there and whether this was another message I had received in some way during my early experiences, or whether my focus was solely on the patients and therefore I had always taken the attitude of just ‘carrying on’.

This again links to the ideas around socialisation of the nurse, and posits the idea that nurses are socialised not to show emotions, linking once again to emotional labour and in keeping with the display rules of the organisation. Within this study this appeared as a barrier to self-care and self-compassion and highlighted the need for a cultural and societal change in how nurses are socialised from the start of their nursing education.

The findings touched on a need to teach nurses to look after themselves rather than getting to the point of burnout. Literature could not be found related to self-care and self-compassion in nursing education, although work has been published on the wellbeing and mental health of higher education students more generally.¹⁰ As stated in chapter 2 there has been research conducted looking at the impact of self-compassion with student (non-nursing) populations (Neff, 2003; Gilbert et al, 2004; Gilbert et al, 2006; Neff & McGehee, 2010; Zabelina & Robinson, 2010), focused on emotional wellbeing and student pressures such as coping with failure. Many of these ideas could be important within the field of nursing due to increasing pressures and the impact on emotional welfare.

¹⁰ <http://www.universitiesuk.ac.uk/policy-and-analysis/reports/Documents/2015/student-mental-wellbeing-in-he.pdf>

5.7 – The environment and the leader

Findings focused on the impact of the environment and the leader as managing increasing pressures and welfare issues, and will now be explored.

Organisational responsibility

Youngson (2008) identifies an increasing concern of failure at a fundamental level with regard to care and compassion, stating that this warrants attention and intervention if it is to improve. It was clear from the interviews that nurses never set out to be uncompassionate but this occurred in the face of feeling overwhelmed, and when unable to manage the day to day emotions of nursing and care giving. If permission to care for the self is absent then the flow of compassion could be impeded (Tierney et al, 2017). Youngson (2012) suggested a need for healthcare workers to rediscover their vocation by strengthening their own ‘hearts’ and learning to provide compassionate care successfully, rising above institutional demands and pressures in order to do this. However, this risks judging individuals if they are unable to provide compassionate care, given that it depends on the situation within which people work. Conversely, Sawbridge (2016, p144) places an onus on organisations, stating the importance of ‘*finding ways to support nurses to top up their emotional bank account regularly in order to be capable of delivering the emotional labour which underpins good patient care*’. The literature therefore stresses the need for both the management of emotions through an individual attending to their emotional needs and the responsibility of the organisation as a means of mitigating ‘*thinner care*’. The promotion of self-care and self-compassion as suggested by my study could allow nurses to top up their emotional bank account.

Positive work environments

The literature highlighted factors enabling positive work environments as: a focus on role modelling and mentoring; communication and trust; civility in the workplace; individual empowerment; and having a leader who modelled positive values and behaviours (McKinley, 2004; Laschinger et al, 2009; Shifflet & Moyer, 2010). Participants during interviews discussed the importance of caring for each other, but acknowledged that it was easier to care for colleagues considered to be friends or who were liked, with recognition that it could only

take one or two individuals to destabilise the environment. The literature related to this placed a focus on the impact of ‘toxic’ individuals on workplace culture, and suggested that leaders, in the first instance address this and prevent it from happening (Peter et al, 2004; Frost, 2007; Kerfoot, 2007). The Kings Fund (2017) ¹¹ in their document ‘Caring to Change’ calls for compassionate leadership, noting that *‘in order to nurture a culture of compassion, organisations require their leaders – as the carriers of culture – to embody compassion in their leadership’* (p4). The report identified that when leaders were able to model high quality and compassionate care, this had a significant impact on the following areas; clinical effectiveness, patient safety, patient experience, efficacy of resources used and the health, wellbeing and engagement of staff (p4). It noted that health and wellbeing of staff can be positively influenced through inclusion, effective role modelling and support, resonating with concepts within my study. However, my findings suggested that within the current NHS culture nurses (including managers) had forgotten how to care for each other and offer each other compassion. This suggests more work needs to be produced exploring how individuals care for each other, alongside the role of the leader.

Accessibility and authenticity of the leader

There was an emphasis on accessibility of the leader and having a leader who cared. Nurses needed to feel like they had permission to care for themselves, with the act of being managed and supported in a positive way being enabling. However, problems could occur if these leaders are part of the same culture in which they have been socialised to ignore their own needs. This may make it difficult to reverse this trend or break the cycle. This indicated a need for input from individuals as well as from structures and the organisation itself, suggesting that the stable base was co-created, placing an onus on joint ownership, rather than splitting responsibility into ‘us and them’.

¹¹https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Caring_to_change_Kings_Fund_May_2017.pdf

The focus within the literature appeared to be the need for authentic leaders, who possessed an awareness of the self and others around them (Luthans & Avolio, 2003; Avolio & Gardner, 2005; Walumbwa et al, 2008). Participants acknowledged that if managers felt threatened then this cascaded down – creating a fearful working environment. These ideas link back to the notion of positive role models. There was a need for a clear vision and leadership style in order for nurses to feel they had a stable base. There was also a need for consistency and coherence, with this then offering containment, enabling staff to feel safe. Leaders are often containers of emotional turmoil, however these leaders also have to feel “held” by the wider organisation to be able to do this (Kings Fund, 2017).

Several participants felt that managers simply set basic governance and advised on tasks to be completed. This went against promoting a culture whereby staff felt able to give themselves permission to care for themselves. Dewar and Cook (2014) proposed a need to *‘foster models of leadership that recognise we are all part of a living community that is complex and unpredictable’* (p1258). They evaluated the impact of a leadership model of compassionate relationship centred care (Dewar & Nolan, 2013; Dewar, 2011) and found the impact and importance of leadership in the promotion of compassionate relationship centred caring, and the need for sound organisational structures and systems. These findings resonated with my study on two levels; firstly, the need for self-awareness and the role of the self in care giving, and secondly the need for a clear vision and leadership style. The literature also identified that leaders effect change by creating trusting stable environments and by valuing emotion (Goleman, 1998; McCormack et al, 2002; Rycroft-Malone et al, 2002). This reinforced the importance of the leadership role in the creation of a stable base, but individuals need to feel enabled by their organisations to do this.

5.8 – Proactive or reactive engagement

Reactive self-care

Participants identified a holistic approach to self-care, acknowledging that it was about caring for every aspect of their wellbeing - physical, mental, and emotional. This resonated with definitions of self-care in the literature (WHO,

1983; DoH, 2005; Lee & Miller, 2013). However, the existing literature focused on preventing ill health, whereas my findings suggested participants could recognise when they were unwell and needed to actively address this, but felt unable to recognise warning signs and early stages of illness. Findings also suggested that they did not have the internal and/or external permission to act in a preventative manner. Hence, self-care was often used reactively, rather than as a preventative measure as suggested by Webber et al (2013), who proposed that self-care should be used in order to avert disease and illness.

Other literature has suggested that self-care is often used only as a buffer against the negative aspects of nursing (Maslach, 2003; Sabin-Farrell & Turpin, 2003; Dominguez-Gomez, 2009; Newall & MacNeil, 2010; Elwood et al, 2011). The negative side effects of nursing as discussed in chapter 2, such as compassion fatigue and burnout (Joinson, 1992; Maslach et al, 2001; Jourdain & Chenevert, 2010; Yoder, 2010; Boyle, 2011; Ledoux, 2015; Sinclair et al, 2017) and vicarious traumatisation and secondary traumatic stress (McCann & Pearlman, 1990; Figley, 1995; Saakvitne & Pearlman, 1996; Gentry et al, 2002; Sabin-Farrell & Turpin, 2003; Kanter, 2007; Elwood et al, 2011; Tatano Beck, 2011). Participants acknowledged that these side effects happened when they were not able to care for themselves, if they put themselves to the '*back of the queue*', or when they were in danger of '*falling off the edge*' when they were attempting to be '*wonder woman*' to everyone else. They were frustrated by this reactive use, questioning whether they were able to apply self-care and, if not, why not.

Current management ideas

Current interventions proposed within the literature that are purported to enable nurses to manage the emotions of caring and to enhance wellbeing are supervision (Lyth, 2000; Edwards et al, 2005; White & Winstanley, 2010; Koivu et al, 2012; Buus et al, 2013), Schwartz rounds (George, 2010, 2016; Goodrich, 2016) and mindfulness (Grossman et al, 2004; Pipe et al, 2009; Hoffman et al, 2010; Cunningham et al, 2013). These interventions and models have proven useful to nurses. Yet it could be argued that they reactively assist nurses in processing emotions related to difficult events, or utilise grounding, mindful techniques in managing emotions. The conceptual framework depicted within

my study calls for permission for nurses to care for themselves both proactively and reactively.

Participants emphasised the importance of being mindful about their own wellbeing, but a sense of helplessness in this respect was also expressed. They openly discussed witnessing difficult events and holding a number of emotions, but rather than being able to process and manage them, they applied tried and tested coping strategies such as '*turning a page*'. '*Turning a page*' appeared to be a short term coping strategy rather than a way of managing and resolving difficult emotions and experiences. An importance is placed within the nursing literature on both resilience (Marsh, 1996; Newman, 2003; Skovholt & Trotter Mathison, 2011) and hardiness (Lambert & Lambert, 1987). The theory developed in my study highlights the central need for permission to self-care and be self-compassionate enabling nurses to attend to their own needs without always being resilient and hardy through repeated exposure, which puts them at risk of closing off without managing and dealing with the emotions of caring.

Lambert and Lambert (1987) suggested that hardiness can be learned and nurses with low hardiness can be taught it in order to counter stress. Yet it is difficult to ascertain whether hardiness is viewed as a coping strategy or a form of self-care? It could also switch off one's ability to identify with patients in order to attend to them compassionately. Current literature reinforces the need to identify with the patient in order to provide compassionate care (Bramley & Matiti, 2014; Haslam, 2015), with my findings also supporting this, making reference to entering a 'journey' together and being able to view the patient as a fellow human being rather than a task.

However, data within my study suggested it could also get to a point where emotions became uncontainable when working so closely with patients. This highlighted the need to provide an opportunity to psychologically process events, rather than just shelving them and relying on repeated exposure to build hardiness. It could therefore be posited that hardiness is employed to cope with a hostile work environment when self-care and self-compassion cannot be

accessed. This could impact upon compassionate care and lead to 'thinner' care that my findings suggested.

Relieving difficult emotions

Another means of managing difficult emotions of caring was closing off and building a wall. Like '*turning a page*', this appeared to be a short-term way of relieving difficult emotions that were often returned to at a later date. Closing off entailed emotionally or physically moving away from difficult situations, and represented a form of self-preservation. It appeared that if this strategy was not in place then there was a risk of becoming overwhelmed by emotions. Patrick (1984) identified that self-preservation represented survival, and suggested if nurses were unable to actively involve themselves in the process, they were potentially at risk of burnout and impairment. Furthermore, Stayt (2009) conducted a phenomenological study with critical care nurses (n=12), to explore the emotional labour of caring for families of critically ill patients. One of the main themes to emerge was the need for self-preservation, which was presented as a strategy used to create space and physical distance in order to avoid emotional involvement. These findings were similar to the experiences of my participants when they discussed moving away from difficult situations. However, this short-term strategy could be viewed as incompatible with compassionate care as nurses distance themselves from patients to self-protect and preserve (Menzies Lyth, 1960). Instead, self-care and self-compassion could be utilised as longer-term strategies to allow for awareness of emotions and the need to process them and care for the self. Many of these ideas resonate with the emotional labour literature discussed in chapter 2. Findings of my study may extend and provide a more critical reading of this literature by thinking about how self-care and self-compassion can enable nurses to be aware, protect and process their emotions whilst managing the display rules of an organisation and the need to provide compassionate care to their patients.

Short term coping strategies were portrayed as useful, in order to not take everything to heart, yet the importance of longer term support and supervision in managing the 'emotional bit' (RMN13) was raised. Within this context self-care and self-compassion are viewed as longer term coping strategies, due to an

awareness of needs and ability to process them. There was the idea that if emotions could be processed, nurses would be in a place to offer better care. This relates to the literature on emotional intelligence discussed in chapter 2 and also literature relating to current emotional intervention in healthcare, including supervision (Lyth, 2000; Edwards et al, 2005; White & Winstanley, 2010; Proctor, 2010; Kahneman, 2012; Koivu et al, 2012; Buus et al, 2013; Wallbank, 2016; MacLaren, 2016), and Schwartz Rounds (George, 2016; Goodrich, 2016), and also my own personal experience as previously recalled. However, the organisations within which participants worked appeared to encourage an element of closing off and carrying on, resonating with the display rules written about in the emotional labour literature (Hochschild, 1983; Morris & Feldman, 1996; Mikolajczak et al, 2007; Huynh et al, 2008; Sawbridge, 2016).

5.9 - Part one summary

Part one of this chapter sought to place my conceptual framework within the context of the current literature base in order to explore and establish its utility. My conceptual framework situates permission as a central concept to enable nurses to care for themselves, with this linking to the management of the emotions of caring for others. There was a dearth of literature relating to permission, in favour of a focus on the difficulties of applying self-care and self-compassion, with embarrassment, guilt and fear of being viewed as selfish, acting as barriers. Furthermore, the ability to recognise the flow of compassion, whereby in order to care for others nurses own needs and wellbeing are taken into account, also appeared important. Within the two participating trusts there existed supervision policies and the need for de-brief following difficult experiences. This suggested permission was in place to process and manage the emotions of care giving in a reactive way, attending to emotional needs following a difficult experience, rather than as a proactive measure and part of everyday nursing practice. Self-care tended to come about when reaching crisis point, forcing staff to move away from following corporate display rules and solely putting the patient first. From the previously discussed leadership literature, self-care and self-compassion have to be embraced by the wider workplace and culture to be effective.

The findings posited that identity and motivations to nurse were also key when thinking about permission to be able to care and be compassionate to the self. The nursing identity appeared to be important with some relating to this in its entirety, and others relating to aspects whilst keeping the core of them as separate. A focus on others, according to the literature, related to society's construction of nursing and the notion of patients coming first. This perhaps made self-caring and self-compassion less acceptable in the eyes of the nurse, due to public perception and society's interpretation of "being a nurse." Embedding the ideas of self-care and self-compassion early on in nursing seems to be important in increasing acceptability and the ability to give the self and receive permission.

In sum, findings of this study and the conceptual framework highlight that needing permission to self-care and be self-compassionate are important in the field of nursing. They offer new knowledge and a fresh understanding of how to address the wellbeing needs of the nurse and how this relates to patient care. These ideas will be further presented in part two of this chapter.

Part two
Reflections, conclusions and recommendations

5.10 – Introduction

Part two of this chapter will present my reflections on the study, the execution of the methodology used, the study's strengths and limitations. I will revisit the research questions and in the context of these will set out to define the original contributions made by my research to the knowledge base. Conclusions will then be discussed followed by key recommendations.

5.11 – Original contribution to knowledge

- Participants held a good understanding of self-care and the facets it encompassed and what it entailed for them. However, the tendency was to use self-care as a reactive coping strategy rather than it being engaged in as a proactive, preventative measure.
- Nursing guidance, policies, reports, the media and nursing colleagues instilled the notion that the patient was a priority. Whilst this was important for the role of a nurse, it was often interpreted in isolation, without consideration of the nurse's own needs, which were pushed or forced aside in favour of others.
- Self-compassion was not well understood, was difficult to define and led to some confusion, suggesting scope for more understanding of its components and its benefits within nursing. The existing literature proposes that self-compassion is useful and has benefits for the wellbeing of the nurse; therefore there is a need for it to be more fully understood.
- Self-compassion when understood was viewed as a part of self-care that required active engagement. Alongside self-care, it was regarded as necessary to apply in order to be 'ok' to give care to others; benefits to the self were often overlooked in favour of caregiving. Hence, it formed

part of professional identity; a tool to allow individuals to live up to their own and society's expectations of what a nurse is.

- Those who regarded nursing as a vocation, with a lack of clear identity or sense of self outside of this, appeared a barrier to self-care and self-compassion. This may have been due to the deep-seated perception of being there to care for others in the first instance, often at the expense of the self.

There may be times where the nursing vocation and role are more nuanced than the above, when nursing as a role is more to the fore and at other times when nursing as a vocation seems to take priority.

- Those who regarded nursing as a role appeared more able to care for themselves, due to being able to distance themselves from the attachment and demands of the organisation.
- Nurse participants appeared to need a stable base to feel safe and secure in their working environment and within themselves. If stability and safeness were achieved then they felt more able to apply self-care and self-compassion.
- There is already awareness within the literature that nurses often hold many competing emotions and face difficult situations in their day to day work. However, findings from this study suggest that if nurses are able to manage the emotions of caring by being self-aware and recognising when they need to apply self-care and self-compassion, then they feel more able to offer compassionate care to others.
- Nurses require permission to be self-caring and self-compassionate. This can take the form of giving permission to the self through the process of taking ownership and responsibility for their own wellbeing, or receiving more formal permission from another.

5.12 – Evaluating and reflecting on the research rigour

As discussed in chapter 3, Charmaz (2014, p337-338) proposed specific criteria for evaluating research using Grounded Theory methodology. These consisted of: credibility, originality, resonance and usefulness. The guiding questions within each of these criteria were held in mind when thinking about the following subsections.

I) Credibility:

- ‘Has your research achieved intimate familiarity with the setting or topic?’

The research achieved a familiarity with the topic of self-care and self-compassion within nursing by producing clearly defined concepts. Charmaz (2014) noted *‘a claim to making scholarly contribution requires a careful study of the relevant literatures, including those that go beyond disciplinary boundaries’* (P338). This was achieved through looking at a broad range of literature, within and outside of nursing, to explore the concepts more widely. New insights and theoretical ideas emerged from the data within this study and were discussed in the context of the current field of knowledge and literature base. In chapter 2, I explored how the terms are currently defined within the literature, noting that some terms are more easily defined than others. This led to an exploration of the terms during interviews, to understand what they meant to the nurse participants. The in-depth interview process allowed me to engage in the nurse’s experience and more fully understand the intricacies and complexities of the concepts and terms under study.

- ‘Are the data sufficient to merit your claims? Consider the range, number, and depth of observations contained in the data.’

The sample consisted of nurses from across different disciplines and specialties. There was a diversity of age, years of experience and agenda for change bandings. This sample enabled a broad range of perspectives and experiences related to self-care and self-compassion to be heard. Interviewees were able to talk about their own experiences and observations of their own clinical environment and those of the wider organisation and NHS culture.

Thirty in-depth interviews were conducted using a semi-structured, flexible approach with nurses in a location of their choosing. The majority of interviews took place in a quiet space within the clinical setting and ranged from 26 to 81 minutes (average = approximately one hour). This provided sufficient time to explore the topic of interest and to allow participants to feel heard. Participants were allowed time at the end to reflect on the interview and to ask any questions. I then allocated time for my own reflections away from the participants, using a reflexive journal throughout the research process. This enabled my own observations, thoughts and reflections to be recorded as I explored my feelings on the topics being discussed, adding to the richness of the data. The data were continuously discussed through the process of regular supervision, to enable an open dialogue regarding the emerging categories. Participant interviews (data collection) were completed until data saturation and sufficiency were reached. The process of this is fully discussed in chapter 3.

- 'Have you made systematic comparisons between observations and between categories?'

The constant comparison method proposed by Charmaz (2014) was utilised throughout the process of data collection and analysis, to compare different emerging categories. For example, the core concept - needing permission to self-care and be self-compassionate - was compared to the emerging categories. This allowed a systematic approach in developing the overall conceptual framework. Data were continuously compared between transcripts, researcher observations and the emerging theory, through use of data immersion, the multiple functions of NVIVO, returning to the literature, the process of supervision, reflexivity, and ensuring alignment with the stepwise process proposed by Charmaz (2014).

- 'Do the categories cover a wide range of empirical observations?'

The participants were recruited from two large NHS trusts, both covering large geographical areas. Although the main focus appeared to be participants' experiences of self-care and self-compassion within their own clinical setting, they also drew on a variety of contexts, including past work environments, previous careers, the university in which they studied, their school and early childhood, their home life, their social settings and their experiences of a wider

NHS culture. Many of their experiences included other people, bringing multiple relational aspects to the data.

- 'Are there strong links between the gathered data and your argument and analysis?'

The data were compared and considered against the existing literature. At times this proved challenging due to the broad scope of the literature. However, this also brought fresh insight and allowed for the building of logic and links. By returning to the literature on a regular basis I was able to explore the emerging categories and concepts. As mentioned previously, links between the data being collected and analysed were discussed during supervision, which strengthened the logical links between the data and my discussion within the findings.

- 'Has your research provided enough evidence for your claims to allow the reader to form an independent assessment – and agree with your claims?'

The findings and original contributions to knowledge provided by this study were regularly discussed with my supervisors, with colleagues at the University of Warwick and within a self-care working group I helped establish at the Royal College of Nursing (RCN). This provided useful access to the views of others regarding the ideas and findings within this study. The amount of data collected and the varied sample strengthen my claims, alongside the stepwise process of data analysis as outlined in Chapter 3 and the supporting appendices. This allows the reader to assess my data from its raw starting point through to the development of the conceptual framework. My findings are also discussed and situated within the current literature base allowing the reader to assess my original contribution to knowledge.

II) Originality:

- 'Are your categories fresh? Do they offer new insights?'

The literature relating to how nurses care for themselves was sparse and, therefore, the categories and concepts provided within the findings of this study are 'new' and 'insightful' regarding how nurses experience self-care and self-compassion. The idea that nurses require permission to care for themselves was a *fresh idea* that built upon the concepts; 'hardwired to be caregivers' – vocation

versus role and ‘needing a stable base’. The ability for nurses within the study to care for themselves and offer self-compassion led to ‘*new insights*’ relating to the impact on themselves and on care giving and how nurses are more or less able to manage and cope with emotions involved in caring. The key conclusions and implications for this research study are detailed later in this chapter.

- ‘*Does your analysis provide a new conceptual rendering of the data?*’

This study shows ‘*a new conceptual rendering*’ in Figure 8 within chapter 4, as represented by the conceptual framework ‘needing permission’. The conceptual framework sets out the process of self-care and self-compassion in nursing by identifying the idea of the need for permission and factors that facilitate or block it. The potential importance within the field of nursing and healthcare more widely was clear, as many participants made the link regarding the ability to provide compassion outwards towards others being impacted upon if unable to care for themselves. This study’s ideas around needing permission will enable further research and exploration within this field.

- ‘*What is the social and theoretical significance of this work?*’

The social and theoretical significance of this work are clearly outlined within section 5.17 of this chapter. It places a focus on the recommendations and implications of this study on nursing practice and policy, nursing research and nursing education.

- ‘*How does your grounded theory challenge, extend, or refine current ideas, concepts, and practices?*’

Findings of this study may challenge current nursing practice with the idea that there should be more focus on the wellbeing of the nurse. Current ideas around the need for supervision, resilience and the processing and management of difficult emotions could be re-examined in the light of the findings of this study, in order to more fully understand current practices.

III) Resonance:

- 'Do the categories portray the fullness of the studied experience?'

The notion of assessing the fullness of the studied experience was managed in three ways. In the first instance, following discussion with my two supervisors, I deemed that theoretical saturation (Charmaz, 2014) had been reached at thirty in-depth interviews. The call to end data collection sat primarily with me as it was not possible for my supervisors to read all of the transcripts; this was when no new data were emerging related to self-care and self-compassion, with all categories and concepts being sufficiently dense (Dey, 1999). The second means of assessing 'fullness' was achieved through the process of member checking, as outlined in chapter 3. Member checking was used initially by paraphrasing and summarising the discussion during each interview to ensure I understood what was being discussed, and to enable the participants to correct me if necessary. Secondly, participants were sent their transcript. Two participants asked for certain words to be removed as they felt they might be identifiable; these words were unrelated to the topic of interest. All participants were very positive in their email correspondence and advised they had no new comments or data to add. Thirdly, constant comparison was used continuously to ensure that comparisons were made between emerging categories and concepts to enable '*fullness*' of the questions under study.

- 'Have you revealed both liminal and unstable taken-for-granted meanings?'

Within this study a number of viewpoints emerged related to how participants experienced self-care and self-compassion. Their own health and wellbeing were often perceived to be 'taken for granted' and pushed aside in favour of prioritising the patient and others. However, participants reflected on the importance of their own wellbeing and were able to consider that their own self-care and the care of others could co-exist. It was often taken for granted and expected that nurses would carry on delivering care no matter what happens. This study showed that they did this, yet sometimes at great personal cost, and part of the reason for this was that nurses felt they needed permission before they looked after themselves, which was not necessarily forthcoming. I reflected that I had also 'taken for granted' the fact that participants would have some understanding of self-care and self-compassion; for self-compassion, this was not always the

case. Other taken for granted meanings included: what it means to be a nurse and overlooking one's own needs but then feeling resentment towards an organisation and on occasion patients because one's personhood is overshadowed by one's professional status.

Charmaz (2014) reinforces the importance of going beyond the obvious in the data which is illustrated through the intricate coding process within my study, moving from the process of initial coding through to theoretical coding and the raising of categories and key concepts. This process was aided through reflexivity, memo writing and supervision. Member checking to try and get beyond taken for granted assumptions during interviews was vital due to the possible expectation that I as a nurse shared a common language with the participants and may have been at risk of not asking naïve (but insightful) questions.

- 'Have you drawn links between larger collectivities or institutions and individual lives, when the data so indicate?'

In this study 'needing permission' was identified as important to the nurses who took part, who came from a broad range of settings. The concept appeared important from a personal as well as a wider cultural viewpoint; data suggested that ideas around permission could translate into people's personal relationships and social settings as well as their work environment. The final conceptual framework poses potential implications for not just the participants within this study, or only nursing, but also for the wider healthcare culture. Furthermore, findings place a reflection on society as a whole, with the idea that the public want nurses who are compassionate to others and, therefore, there needs to be a recognition of nurses' humanity, with permission for them to attend to their own needs. In order for this to happen, time and financial investment may be required.

- 'Does your grounded theory make sense to your participants or people who share their circumstances? Does your analysis offer them deeper insights about their lives and worlds?'

Throughout the interviews, participants reflected on the issue of self-care and self-compassion and how they fit within their 'lives and world'. Many of them

said they had not really considered these concepts prior to taking part in the study; the need to care for themselves only became important when they were struggling in some way. Within interviews, many participants stated that the discussion had made them think, with the need to care for themselves making sense. One participant even asserted I had given her permission to care for herself by asking her questions about this. Several of the participants felt that self-care and self-compassion should be embedded within nurse education, resonating with the fact that they felt it appropriate and important that these concepts were part of their ‘world’ of nursing.

IV) Usefulness:

- ‘Does your analysis offer interpretations that people can use in their everyday worlds?’

This study proposed that self-care and self-compassion were important and, when permitted, can make a difference in the ‘everyday worlds’ of individuals. This included their own wellbeing and how emotions were managed when offering care and compassion to others, thus making a difference in the ‘world’ of others. Findings from the study may provide useful information to other nursing groups, wider healthcare populations and nursing education. Further work may be conducted to assess how they translate with other healthcare populations and those early in their nursing careers, particularly in relation to the need for permission to self-care and be self-compassionate.

- ‘Do your analytic categories suggest any generic processes?’ - ‘If so, have you examined these generic processes for tacit implications?’

Within the study findings a ‘generic process’ was suggested regarding the need for permission to self-care and be self-compassionate. Nurses knew about the need to self-care, and already held the knowledge in mind ‘we know what we need to do’, but were unable to engage in it. The tacit implications explored within this were the processes around self-care being blocked or pushed aside in favour of prioritisation of patients and other tasks. This was often a hidden and unconscious process, with a suggestion that some participants were not aware that their own needs were being pushed aside, until negative consequences occurred for them (i.e. ill health).

- 'Can the analysis spark further research in other substantive areas?'

The study findings have the potential to 'spark' further research, as explored in section 5.14 of this chapter.

- 'How does your work contribute to knowledge? How does it contribute to making a better world?'

The study findings have provided new knowledge to contribute to the field of nursing (see page 216). The idea that nurses require permission in order to care for themselves could impact upon nursing practice and policy, nursing research and nursing education. If nurses are equipped to manage the more difficult emotions related to caring for others, this may protect them from some of the negative effects associated with nursing. It may enable them to care for themselves proactively, rather than as a reactive measure when they are already unwell, thus improving the working lives of nurses and creating a 'better world'. It could also mean a 'better world' for patients, as they may receive care from those who are not on the brink of physical or emotional exhaustion.

5.13 – Reflections on specific methodological areas

5.13.1 – The Literature Review

As discussed in chapter 3, there has been much debate in the field of Grounded Theory as to when the literature review should take place (Glaser & Strauss, 1967; Glaser, 1978; Charmaz, 2006). Charmaz (2006, p166) identified the usefulness of conducting an initial review to explore the topic of interest and to aid in the formulation of research questions. She then suggests letting the literature '*lie fallow*' until a later stage of the research. In this study I conducted a review of the literature prior to study set up and data collection, in order to explore my topic of interest. When I initially searched the literature there were few studies directly focusing on my topic and this led me to broaden the search, as discussed in chapter 2. At times this was difficult as much of the literature seemed to be on the periphery of the specific field of interest, although this added insight, sensitised me to concepts and justified my research by highlighting a gap within the current knowledge base. I continuously returned to the literature once data collection and simultaneous analysis commenced. This allowed the process

of comparing my data to the current literature base to ensue. For example, when the categories and concept emerged related to ‘Hardwired to be caregivers’, literature on nursing identity, professional role and motivations to enter the field of nursing was considered. This enabled the expansion of ideas, the construction of categories and facilitated the original insights and contributions of this study. The process of the initial review of the literature and returning to the literature throughout also promoted familiarity with the topic as proposed by Charmaz (2014) as a means of enhancing credibility.

5.13.2 – Reflexivity

My position within the research was important. I have 19 years’ experience as a mental health nurse, working in a variety of different settings. I also have significant experience in the field of compassion due to my current role as a Clinical Nurse Specialist, which entails providing compassion focused therapy (CFT, Gilbert 2010) to patients with an eating disorder. I have completed a period of teaching nurse mentors a compassion focused approach to adopt for themselves and with their mentees, which centres on self-care and self-compassion. Alongside my clinical and teaching roles, I sit on a self-care working group with the RCN and have been actively involved in the Healthy Workplace, Healthy You campaign¹² which focuses on the wellbeing of healthcare staff. This experience could be viewed as inside knowledge and, therefore, requires an acknowledgement of its impact upon the research conducted. Reflexivity was used in order to examine my own position, alongside exploring the experiences of the participants through the process of in-depth interviews and on-going analysis. The process of supervision helped maintain my own position within the research. The position of the researcher as part of the research process is acknowledged by Charmaz (2014), within the constructivist approach, emphasising the idea that I could not be completely separate from the study.

¹² <https://www2.rcn.org.uk/newsevents/campaigns/healthy-workplace>

In terms of my epistemological stance as a social constructivist, this PhD was my first experience of conducting qualitative research and, therefore, epistemology was not something I had previously considered. During initial supervision and PhD training I found the subject to be challenging. I began to explore the literature and use the knowledge of my two supervisors to examine my own notions of what constituted knowledge and its construction. Social constructivism was a useful framework for conducting interviews and analysing data. This approach allowed the recognition of social context and influence, but also the idea that there are multiple realities, with the participants and myself having access to their own realities and the meanings and experiences within that.

Within the constructivist perspective, there was recognition that my findings were context specific, to the time and place under study. Hence, another researcher with different experiences and at a different time could have produced different findings. Charmaz (2006) identifies that reflexivity is a means whereby the reader can assess and determine how far the researcher's background and knowledge have influenced the inquiry. The need to recognise and explore the effect of the 'self' within the research process when adopting qualitative methodologies is widely acknowledged (King, 1996). This meant that I needed to be aware of my own influence over the research, acknowledging my experience, assumptions and beliefs. I also needed to be aware of my interactions with the participants and within the interview process.

Many of the participants acknowledged that they felt comfortable talking to me because I was a nurse. They reflected that they felt I understood the experiences they were discussing and felt at ease talking even when discussing difficult and distressing topics. I had no difficulties recruiting nurses, with many coming forward to take part through a single recruitment drive (sending the recruitment poster once to the research departments based within each of the two trusts).

I feel that my role as a nurse was largely beneficial as I gathered rich data, with participants openly discussing their experiences and rapport being easily established. There felt to be an element of trust in the room, as I was viewed as 'one of them', linking back to some of the ideas discussed when considering the

need for a stable base. Yet from a personal point of view, at times my ‘insider’ knowledge could be difficult; I felt a great deal of sadness for some of the experiences I was listening to, particularly when thinking about changes within the NHS, the public’s perception of nursing and overall the sense that nurses were not able to care for themselves. When distress was apparent in the interviews I found it difficult to remain neutral and felt like my ‘nurse therapist hat’ was about to be put on. I managed to refrain from this during the interview, but when the recording stopped I was quick to check that the participant was ok, and also followed this up in my email correspondence. From a personal perspective and acknowledging the need to manage my own emotions, I used my reflexive journal, supervision and general discussion with my nurse husband to manage how I was feeling, with a particular focus on my sadness.

My own experience of witnessing and dealing with difficult situations as a mental health nurse and my constant reference in practice to having a ‘thick skin’, may have influenced the construction of the concept ‘managing the emotions of caring’. This was particularly related to dealing with repeated exposure, and the participants referencing the need to ‘close off’ or develop the skin of a ‘rhino’. I also related to the notion of ‘a nurse is who I am’, with nursing being very much a part of my own sense of identity. I was careful to ensure my constructions of these categories remained grounded in the data and the participants’ experiences, by using the constant comparison method during ongoing data collection and analysis. However, it is important to recognise that these categories held personal significance.

5.13.3 – Using two NHS trusts

The decision to use two NHS trusts was made in order to capture and recruit staff from across the nursing disciplines. The trusts were chosen based on locality and my experience of previously working with one trust and currently working for the other. It was felt this would aid research access, although for my employing trust, this took far longer despite ethical approval being sought for both trusts at the same time. This meant that recruitment from Trust one was enabled more quickly. Fortunately when the need arose to theoretically sample within the research, access to both study sites had been gained. The two trusts were

geographically close, making data collection manageable for me as the researcher, but this could be viewed as a limitation due to the sample being derived from one geographical area.

5.13.4 – The sample

The sample (n=30) and the depth of data collected from different nursing disciplines and specialties enhanced the ‘*trustworthiness*’ of the study (Charmaz, 2014). The number of participants was similar in size to that recommended by Charmaz (2006) to develop a well saturated theory (n=20-30), and Stern and Porr (2011) who recommended 30-40 interviews to provide data sufficiency or to reach data saturation. However, it is important to bear in mind that this will depend on the breadth of the topic being explored, and the homogeneity of the population being studied.

The quality, depth and amount of data collected was vast with many transcripts exceeding 15,000 words. A number of different nursing disciplines were sampled (RMN, RGN, RNLD, Dual qualified). However, although two of the RMNs worked within child and adolescent mental health, no children and young people nurses (RNC) came forward during recruitment. The reasons for this cannot be known and it would be interesting within future research to explore self-care and self-compassion with this population in order to establish any similarities or differences. The cohorts for student nurses applying to be RNCs are much smaller than other nursing disciplines, which may impact upon key messages being given during nurse training, yet the similarities or differences at this stage are unknown. I did try to theoretically sample a RNC via one of my RNC friends who worked in Trust one, but this was not possible due to the lack of response I received when trying to set this up. However, outside of work my friend did show an interest in my study and through discussion highlighted that she largely used supervision and de-briefing as a means of caring for herself. She also reflected on the importance of humour and close relationships with colleagues, which resonated with many of my study’s findings.

Due to the fact that I am employed by Trust two and I had a working knowledge of the research department in Trust one, it is useful to point out that I knew 8 of

the participants in some way. I had not directly worked with any of them but I had worked within the same hospital. This may have proved positive in that they felt more comfortable talking to me for the purpose of the interview, and negative in the sense that they may have felt a pressure to take part. They may also have held back on what they discussed in order to save face or uphold the existing perception I had of them. It is important to note that I did not directly approach any of the participants individually to take part, but rather they may have seen my name on the recruitment poster and wanted to take part because it was me rather than the field of inquiry. However, this was not apparent in the interviews, with all participants showing an interest in the area of self-care and self-compassion and all were able to freely discuss their experiences.

Some of the participants were very articulate and seemed to want to give as much time as needed for the interview. Some were very busy and provided as much time as they were able to during a busy shift, or had allocated 60 minutes protected time within their diaries to take part. Two of the interviews were briefly interrupted, one by a phone call and the other by a member of staff due to an incident within the clinical environment. This caused a pause in the process of the interview, but once the interview was returned to it did not appear to impact on the flow of information being provided.

It was anticipated that there might be differences in the experiences of self-care and self-compassion across the different nursing disciplines, yet this appeared to not be the case. Hence the findings in chapter 4 were presented as a whole nursing population rather than separated according to discipline and specialty. One of my assumptions had been that mental health nurses (like me) would have a greater understanding of self-compassion. Yet mental health nurses showed the same level of understanding or confusion as the other nursing disciplines. On reflection I had learnt its meaning during my current clinical role and through the process of being taught to deliver CFT as a nurse therapist, so my assumption may have been misplaced.

Data sufficiency was determined by theoretical saturation and discussion with my two supervisors. The recruitment strategy using a single research poster (see

appendix 2) exceeded expectation, with potential participants responding quickly and showing an eagerness to take part. This could highlight the perceived importance of the field of inquiry. The participants who showed an initial interest but did not take part (n=23) were interesting as after the initial contact and my response inviting them to meet for interview, no further response was gained. The reasons for this are not known, although within my reflexive diary I did contemplate whether it could be due to workload, time pressure or simply changing their mind about taking part. I also reflected that following completion of 30 in-depth interviews and the perception of reaching theoretical saturation, I did not feel further interviews were needed; had saturation not been reached, I may have tried to engage harder with these other potential participants.

A process of theoretical sampling took place, with me approaching newly qualified nurses from those that had expressed an interest in order to further explore motivations to nurse, differences with levels of experience and to discuss whether self-care and self-compassion exist within current nurse training. I also needed to theoretically sample nurse leaders following a lead in the data related to effective leadership. I achieved this by looking at those individuals who had already expressed an interest and by asking other participants whether they knew any nurse managers/leaders that would wish to take part. Other participants appeared keen to help and showed my research poster and information sheet to potential leaders, with 3 being recruited in this way. This allowed me to follow the lead within the data and remain closely aligned to the Grounded Theory method as proposed by Charmaz (2014).

There appeared to be no gender differences in experiences relating to self-care and self-compassion between male (n=6) and female (n=24) nurses, although a larger male sample might have produced differences. There also appeared no differences relating to the data collected dependent on interview environment or those interviewed within or out of work time. All participants, apart from two, completed their nurse training in the UK.

5.13.5 — Data collection and analysis

I) Interviews

I explored the data collection methods within Grounded Theory methodology and chose to use semi-structured interviews. I am aware that I could have used focus groups or field observations as alternative methods, but I felt that interviews would provide the richness of data needed to study the field of inquiry. I felt that focus groups would be challenging to set up with the nursing population due to the diversity of the sample being recruited from and due to the differing shift patterns worked. I also anticipated that self-care and self-compassion might be personal topics to discuss and that individuals may feel more comfortable in an interview situation with one person rather than within a group. With regard to observations I felt that although some self-care and self-compassion elements were observable many of them were not, and were rather emotionally driven or internal processes that may not be seen.

Despite not having conducted qualitative research previously, I felt confident about using interviews to collect data. As a nurse, I am used to talking to a range of individuals through the process of assessment, nursing intervention and therapeutically; I felt many of these skills would be transferable to the research interview. Hunt et al (2011) identify that an appreciation of the differences between interview contexts and the challenges this may pose, can help the transition between clinical interviews and the qualitative research interview. I felt my skills lay in developing rapport and engagement, and it was hoped that participants would feel safe and comfortable when talking to me. I needed to recognise that my role as a researcher was different from a nurse, with this being achieved through the processes of reflexivity and supervision. Colbourne and Sque (2004) advise asking the question *'am I analysing participant narrative through the eyes of a researcher or through the eyes of a nurse with a different knowledge base'* (p298). This highlighted the need for awareness of how professional socialisation could get in the way. This question was useful not just for data analysis but also when interviewing to ensure my role in the room remained clear. Colbourne and Sque (2004, p 304) also recommended the following:

- A purposely restricted or constructed research persona can be perceived as false by participants (and the researcher) and may not help the research process or prevent subjectivity.

- Role conflict need not be an issue if the nurse researcher is able to rationalise the benefits of nursing attributes in the research process'.

For my first interview I felt nervous and under pressure to ensure I asked all my questions, despite previously feeling confident. On entering the room I realised the participant was nervous as she said she hoped she could 'give me what I needed'. I realised at this point that it was not about always ensuring all questions were asked, but rather that I allowed my participant to talk and freely discuss her experiences.

I tried to ensure all my questions were open, as I did not want to lead any of the answers. My two supervisors checked some of my early interviews; they were happy with my interviewing style and were pleased with the amount and depth of data being collected. This gave me the confidence to proceed and then move towards theoretical sampling to follow up leads within the data, particularly relating to motivations to nurse and the impact of leadership. The use of theoretical sampling in relation to the interview guide felt challenging at times; I initially felt uncomfortable adding questions, although I quickly realised it was a necessary and important process in order to remain aligned with the Grounded Theory method.

I was mindful throughout the interview process that I was not bringing my own agenda into the room, whilst acknowledging that I was still a part of the research process. Madill (2007) proposed that participant experience are accessed, through the process of interview by the researcher, adding that what was said would be a co-constructed version of the 'truth'. Charmaz (2014) supported this view as previously discussed in chapter 3. This process reinforced the importance of reflexivity and being aware of my own position.

II) Analysis

The Grounded Theory approach followed (Charmaz, 2014) involved theoretical sampling, coding, memo writing, constant comparison and theoretical saturation. Although this process seemed very clear at the outset of the research, in practice this was far more challenging and at times felt a daunting task due to the amount and depth of data collected. Initial coding was time consuming and could feel chaotic as the amount of data increased. I commenced the process on paper using highlighter pens, hand written notes, post-it-notes and hand written mind maps. However, as the data set increased this process was not adequate in isolation, as it became difficult to view the whole data set and move between transcripts, codes and emerging concepts. Following a thorough discussion with my supervisors and training on NVIVO, this computer software programme was used to organise data. NVIVO enabled me to move more easily through the emerging concepts, facilitated the constant comparison method and provided an audit trail for the data analysis. This process is further discussed in Chapter 3.

5.13.6 – Ethical issues

There were no significant ethical issues during the course of the study, possibly because of its careful planning and consideration of how to address respect for autonomy, informed consent, beneficence, non-maleficence and justice, as detailed in chapter 3.

Some distress was expressed during a number of interviews (n=5) due to participants acknowledging that they were not able to care for themselves, remembering difficult experiences, feeling they had been mistreated by their organisation or sadness at changes within the NHS. These issues were dealt with in the room by checking participants were ok to continue and allowing them to express their thoughts and feelings. All participants wished to complete their interview. Once recording ceased I checked they were ok and followed this with email contact the following day when I thanked them for taking part. Many of the participants, not just those that experienced distress, reflected that they had found the process of talking during the interview to be cathartic, adding it had caused them to think about how to care for themselves more in the future.

From a personal perspective I used the process of supervision and my reflexive journal to manage many of the emotional subjects being discussed. This was to prevent me ‘holding’ on to difficult emotions and is a skill I use as part of my nursing role.

5.14 – Study strengths and limitations

I was new to qualitative research, so I was careful to follow the research method proposed by Charmaz (2016), in order to enhance rigour. I lacked confidence initially due to my limited experience and ‘imposter syndrome’. I completed as much early training and reading as possible and met with my two supervisors every 4-6 weeks throughout the period of study. Therefore, one of the study strengths was found within the precision of application and adherence to constructivist Grounded Theory.

Another strength was the original and new contribution to knowledge. There was a dearth of literature related to the field of inquiry, with this remaining the case throughout the period of study. Hence, the research contributed new and significant knowledge, which could influence nursing practice and policy, incite further research or impact upon nursing education. Participants who took part in the study reflected on the importance of the field of inquiry, and the eagerness and ease of recruitment highlighted that it was a topic of interest. Two of the senior managers who participated asked that I report the findings on completion within the participating trusts, again emphasising the perceived importance of the topic. Alongside this, in conjunction with RCN staff, we set up the self-care working group, which placed self-care and self-compassion high on the nursing agenda, with the expectation that my research would impact upon nursing guidance.

If the study were to be repeated it would be interesting to sample RNCs to ascertain any similarities or differences, and other healthcare professionals. There was a lack of data related to positive recollections of self-care and self-compassion, which suggested that participants had a particular experience or story to tell. There was not a lot in the data that stated, ‘yes I care for myself and it makes a difference’. Most of the quotes were more generic regarding ‘how can

we care for others unless we care for ourself'. This could be viewed as a limitation and if repeated a larger sample size or sampling from other geographical locations may have aided looking into this phenomenon further. The two participating trusts did not utilise Schwartz rounds, but did utilise supervision in certain departments. Therefore the impact of supervision could have been looked at, or Schwartz rounds introduced.

5.15 – Conclusions

This study set out to explore the experiences of self-care and self-compassion with nurses, alongside looking at how this related to compassionate care giving. The study achieved this by using constructivist Ground Theory to identify and co-construct codes, categories and the resultant theory related to the field of inquiry. When I set out on this journey I had assumed that self-care, self-compassion and compassionate care were terms which participants would have access to in order to explore the meanings for them, in their worlds and allow me to explore their realities and make sense of them through the process proposed by Charmaz (2014). However, this study was complex and caused me to question my own position and assumptions within the research throughout. The terms were challenging to define and relate to at times, and there appeared a frustration that although the nurse participants 'knew' they needed to care for themselves and offer themselves kindness and compassion, engaging in it was more complicated. Findings suggested that nurses had to feel more comfortable with the idea of caring for themselves in the first instance as both the literature and this study suggested that the default position was to be self-blaming and self-critical rather than self-compassionate, with self-care often overlooked as patients were positioned as the priority. Compassionate care related to a personal connection with patients and how they cared for another human being. Consensus held that compassion was innate and formed part of the nursing character, and therefore could not be taught. However, barriers and facilitators existed that could compromise or enhance compassionate care.

The interview process was emotive throughout, with many participants reflecting on the cathartic outcome of taking part. I was often left with many emotions from

the interview process primarily a feeling of sadness that self-care and self-compassion could be so difficult to access and employ when needed.

The study highlighted the importance of forming a clear nursing identity and sense of self; this appeared related to the ability to be self-caring and self-compassionate. The literature drew on ideas around a 'calling' to be a nurse and taking a vocational stance, alongside another viewpoint of a professional role. Whilst my study supported both of these stances, findings suggested more of a blurring of the two and that the nursing identity could be prone to change over time. This was largely down to organisational commitment and attachment, alongside feelings of receiving support and being valued within the work setting. Self-care and self-compassion appeared easier to access as an individual moved away from the attachment to their organisation, however this could also be down to a shift in priorities and being pushed towards the need to care for the self, following a difficult event. I began to question my own nursing identity, when it was formed, was it complete or as with many of my participants does it remain a fluid process? By interviewing 30 nurses across the nursing hierarchy I was privileged to be able to access so many ideas around the identity of the nurse and as a result acknowledged the personal nature and humanity within it.

Findings revealed a perception that nurse training was not adequate in enabling individuals to be self-caring and self-compassionate. Being given permission to care for themselves from early on in childhood and within their nursing career appeared to facilitate and increase its acceptability into everyday practice. The literature highlighted the importance of support during the transition from student to qualified nurse, due to the impact of the realities of the job on the ideals of the nurse.

Alongside these early key messages there appeared a need for nurses to feel safe and secure, requiring a stable base to cope and manage day to day distress and the level of change within the current NHS. Feeling supported and having effective leadership were cited as two of the main facilitators to achieving a stable base, with the existing literature also placing importance on leadership and a supportive work environment. The findings of my study acknowledged the

fragility of certain work areas. It identified that the environment itself could threaten nurses' ability to feel safe and secure, which in turn appeared to impact on the ability to give themselves permission to attend to their own needs. Participants appeared to trust me during the interview process, in terms of being able to discuss sensitive information regarding their own thoughts and feelings about the areas in which they worked. Throughout I was aware of my own position and need to report should I come across any bad practice or areas of concern. This did not materialise, yet many of the discussions led to reflection of my own position within the NHS and the roles I have held.

Findings and the existing literature base acknowledged the complex emotions often involved in care giving. Interview data placed a focus on positive gains from caring, alongside the need to recognise and learn how to cope with often difficult emotions encountered when caring for another individual. Findings suggested that self-care and self-compassion are used only when absolutely necessary, when nurses are already struggling, rather than in a proactive way to prevent burnout and compassion fatigue - as a way of increasing resilience. Short term coping strategies were employed in favour of longer term strategies, to enable nurses to carry on and see the next patient. Yet this often led nurses to reach a point where they felt frustrated, their compassionate care being compromised as they were unable to engage in activities that may prevent or lessen the negative consequences of care giving. Some of these discussions caused conflict for my role as researcher, with me often feeling the need to be nurse or therapist in the room. However, due to the quality of supervision I received, and my own role awareness, I felt able to step away from this and be mindful of my role as a researcher to explore the participant's perspective, rather than offer advice or counselling.

Within my study nurses acknowledged the need for a flow of compassion, recognising the importance of caring for themselves as well as others, but becoming stuck when active engagement was needed. In order to engage, permission was seen to be key - from the self and others. Individuals needed to take ownership for their own self-care, to be self-compassionate. Yet recognition from their managers, organisation and the nursing culture as a whole was also

required. This more formal permission appeared to make the concepts of self-care and self-compassion acceptable, negating feelings of guilt from the nurse, and avoiding their needs being pushed aside. The existing literature base was minimal relating to the notion of permission, yet this appeared key if nurses were to care for themselves, suggesting a significant original contribution to knowledge.

The participants engaged fully in the research process. Topics and themes were far more emotive and complex than anticipated, with the resultant conceptual framework showing how challenging the process of caring for self and others can be. This study, as stated above, makes an original contribution to knowledge. In order to progress its findings, further work would be useful as laid out in the following section.

5.16 – Recommendations and implications

5.16.1 – Nursing practice and policy

This research has provided an increased awareness of the issues related to self-care and self-compassion in nursing. It has noted the many facilitators and blocks in nurses being able to give themselves or receive the permission to care for themselves whilst caring for their patients. If nurses are able to care for themselves in a proactive way, then they are likely to experience a greater sense of wellbeing and feel more equipped to manage and process some of the difficult emotions that can occur when caring for others.

Within nursing policy and guidance, such as the Code (NMC, 2015), there is a focus on caring for patients, and whilst this remains the priority, there is also a need for a focus on the care of the staff. As this study has highlighted, active engagement in self-care and self-compassion is required. Hence, even if recognised within nursing policy and practice there is a need for adequate provision, formal acknowledgment and legitimisation for it to occur. The ability to self-care and be self-compassionate should be embedded within the nursing culture to enable nurses to use these approaches continuously rather than in a reactive manner in response to a difficult situation. Thus, proposed interventions,

procedures and policy need to state that active engagement in self-care and self-compassion is acceptable within the healthcare environment.

A means of achieving the above could be through the formulation of formal policy and procedure, clearly outlining the rationale for and acknowledge that nurses should make time to care for themselves. If nurses are given this formalised permission then this may increase accessibility and acceptability, thus making caring for the self a part of nurses duty of care.

5.16.2 – Nursing research

Although this study showed promise in terms of the findings and added to the dearth of literature related to the topic of interest, further research would be beneficial. This study suggested the following areas for research:

- Research suggests that self-care and self-compassion may have a positive impact within nursing; yet how this is achieved is unclear from the current literature and evidence base. It would therefore be useful for further research to be conducted in order that this potential impact can be explored and measured. Qualitative research has provided a useful insight into experience and meaning. Further mixed method research may be useful, in order that alongside experience, relationships can also be tested (e.g. impact of engagement in self-care on compassion fatigue and burnout).
- Development of a self-care and self-compassion questionnaire based on the findings of this study in order to quantitatively measure a nurse population on a larger scale. Self-compassion and wellbeing questionnaires exist, however many of the concepts found within this study are not included. These questionnaires were discussed in chapter 3. The questionnaire could focus on the following themes:
 - Understanding the terms

- Nursing Identity (vocation versus role)
 - What motivates nurses to enter the profession
 - Impact of feeling stable and safe within the environment in which they work.
 - Acceptability of self-care and self-compassion.
 - Engagement in self-care and self-compassion
 - Whether nurses feel permitted to care for themselves
- Conducting research with other healthcare professionals, such as healthcare assistants and doctors, to assess whether there are any similarities or differences with caring for the self. Grounded theory has proved useful in developing a conceptual framework within this field of inquiry; similar studies with other healthcare populations or different nursing samples could be conducted using this methodology.
 - The current literature identifies newly qualified nurses as at risk of early career burnout, therefore there is a need for this group to be provided with information on how to care for themselves, with this then being evaluated as to its efficacy and impact.
 - Development of teaching materials, based on the conceptual framework for this study, aimed at both pre-registered and registered nurses, to enable self-care and self-compassion to be embedded within practice from early in their careers, with a pre and post testing periods to enable assessment and measurement of effect.
 - The literature suggests the importance of authentic leaders and the impact they have on the clinical environment. Therefore, research could be conducted with nurse leaders and their ability to role model the importance of self-care and self-

compassion, measuring the impact of this for the nurse within the clinical environment.

5.16.3 – Nursing education

Findings from this study suggested that nursing identity played a key role in being able to give self or receive permission to self-care and be self-compassionate. As the literature indicated, nursing identity developed before and during nurse training. Therefore, if the concepts within this study were embedded within nursing education, nurses may feel able to care for themselves from early on in their careers. This would aid in protecting them from the more negative effects of caring such as early burnout and compassion fatigue. It could also enable them to be positive role models to future nurses. This study suggests the following areas for nursing education:

- Newly qualified nurses are entering the profession at a difficult time, when there is much change and reconfiguration, so there is a need to protect these individuals and ensure they are able to care for themselves alongside caring for their patients.
- Empowering student nurses and nurses to care for themselves and help them to understand that being a nurse and caring for others does not mean sacrificing their own self-care and wellbeing.
- As part of the self-care group with the RCN, I have written a self-compassion case study that will be published in the new nurses handbook for 2018. This will be sent out to all new nurses who hold membership with the RCN and will therefore target the nursing population on a large scale. This identifies that self-compassion and self-care are being acknowledged as important within nursing.

- A module on self-care and self-compassion could be formulated and embedded within the nursing curriculum, allowing access to early messages around the need to care for the self. This would permit nurses to care for themselves, as it would be a formal part of nursing education.

5.18 – The end

I leave the final words to two of the participants who gave their time to take part in this study:

‘I just wanted to congratulate you for this because I’ve never had, this is the first time I’m hearing somebody really talking about self-care you know. It’s all about the patients so you sitting down thinking about that is really, I hope you get what you want, you get your questions answered. It’s really, really important’ (RGN5)

‘I think we’re going to lose nurses a lot younger, you know they’re gonna come through, they’re gonna qualify and if we don’t support them we’re going to lose them at quite a young age and let’s be honest nursing can’t afford to lose any more nurses. So we do need to start helping them to care for themselves’ (RGN2)

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APPENDICES

Appendix 1: Literature Search Strategy

Appendix 2: Appraisal of the Literature

Appendix 3: Recruitment Poster

Appendix 4: Participant Information Sheet and Consent Form

Appendix 5: Interview Guide

Appendix 6: Examples of Initial Codes & Initial Coding process

Appendix 7: Example of Focused Codes, Categories and Data

Appendix 8: Theoretical Coding

Appendix 9: Theory Development

Appendix 10: Example of a Research Memo

Appendix 11: Mind map / clustering - Initial Codes of the concepts as described by the participants

Appendix 12: Example of a Reflexive Journal Entry

Appendix 13: Letters of Access and Ethical Approval

APPENDIX: 1

Literature Search Strategy:

As stated in Chapter 2 the literature were searched prior to data collection to establish what is known on the topic, the gaps in the knowledge base and to help inform the final research questions. The literature was then returned to once initial analysis began, in order to identify any new knowledge and to inform ideas and the construction of theory. The rationale for this approach to the review of the literature is described and justified in Chapter 3 and further discussed in Chapter 5. The literature search aimed to take a systematised approach to both the search and review process.

The search strategy aimed to fully maximise the potential of retrieval of documents relevant to the field of interest. The titles and abstracts were read and scrutinised in order to identify whether they related to the field of interest. If related, full texts were retrieved and reviewed. No articles were rejected if related to the field of interest.

See table below for search criteria, key terms, groupings and inclusion / exclusion criteria:

Search terms	<p><u>Initial terms:</u> Compassion*, Self-Compassion*, Self-Care*, Compassionate Care, Compassion AND Care, Compassion AND Nursing, Self-Compassion AND Nursing, Self-Care AND Nursing, Nursing History, History AND Compassion, Compassion Satisfaction, Compassion Satisfaction AND Nursing, Compassion Fatigue AND Nursing, Burnout, Burnout AND Nursing, Secondary Traumatic Stress Disorder, Secondary Traumatic Stress Disorder AND Nursing (AND care), Vicarious Traumatization, Vicarious Traumatization AND Nursing (AND care), Emotions AND Nursing, Emotional Labour, Emotional Labour AND Nursing, Emotional Intelligence AND Nursing, Nursing Supervision, Nursing AND Supervision, Schwartz Rounds, Mindfulness AND Nursing, Mindfulness AND care, Mindfulness AND Healthcare, Resilience AND Nursing.</p> <p><u>Additional Terms searched whilst the discussion chapter (Chapter 5) was being compiled:</u> Leader* AND Nursing, Leader* AND Compassion, Nursing AND Calling, Nursing AND Sacrifice, Nursing Vocation, Nursing AND Vocation, Self Protection, Self-Protection AND Nursing, Hardiness, Hardiness</p>
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	AND Nursing (AND Compassion), Self-preservation, Self preservation AND Nursing
Databases searched	<p>Medline, EBSCOhost, Cinahl, Psychinfo, ASSIA, Cochrane, Embase and Pubmed.</p> <p>The grey literature was also searched as described in chapter 2.</p>
Part of journals searched	Title and abstracts initially searched, then full articles retrieved which presented relevance or links to this study and the terms of interest.
Years of search	No date restriction placed on the search, due to wanting historical context literature. Once data collection had commenced and ongoing analysis, 2014 onwards were searched in order to identify new literature, and to follow leads within the data.
Language	English language only, including articles that had been translated into English.
Types of studies to be included	Qualitative and quantitative studies were included. Due to the dearth of literature related to the field of study I also included narratives and opinion pieces.
Inclusion criteria (why did you include it?)	<p>Studies were included if they related to the field of inquiry and provided useful information. Due to the limited literature directly related to self-care and self-compassion, all studies were included in the literature review, including narratives, systematic reviews and opinion pieces.</p> <p>The literature review also included brief discussion of broader terms that appeared as related during the initial searches to enable related topics to be searched, with above criteria adhered to.</p>
Exclusion criteria (why did you rule it out?)	Literature published in other languages (unless translated).

Initial results of the database searches

	Databases*								
Search Terms	1	2	3	4	5	6	7	8	Results after filtering and removal of duplicates
Compassion	19	1465	42	406	21	1	361	0	22
Self-Compassion	0	43	1	91	4	111	58	0	23
Self-Care	0	36	85	134	11	43	949	1	12
Compassionate Care (including education)	109	663	10	261	1	18	10	6	41
Broader associated terms (from above and combined with the primary concepts)									
-Compassion									15
Satisfaction									13
-Compassion fatigue & Burnout									18
-STS & VT									13
-Emotional Labour									8
-Supervision									6
-Mindfulness									7
-Resilience									3
-Schwartz Rounds									
Total									181

*

- 1 – Medline
- 2 – EBSCohost (inc Cinahl)
- 3 – Psychinfo
- 4 – ASSIA
- 5 – Cochrane
- 6 – Embase
- 7 – Pubmed
- 8 – Other sources

Appendix 2: Appraisal of the Literature

Author / Year	Study Aim(s)	Study Design and Methods	Main Findings	Comments
Compassion				
Kneafsey et al (2015)	<p>To report findings from a qualitative study of key stakeholders perspectives on compassion within a healthcare context.</p> <p>To present a framework for compassionate interpersonal relations.</p>	<p>-Pragmatic, exploratory, qualitative design.</p> <p>-9 focus groups were completed with academic staff (n=13), healthcare students (n=12), clinicians (n=10) and service users (n=10), in total (n=45).</p> <p>-Data analysed using thematic analysis.</p>	<p>Four themes emerged:</p> <ol style="list-style-type: none"> 1) Compassion: 'A big word that you can't summarise in one'. 2) Recognising compassion: Positive communication and consistency. 3) Losing compassion: when the system takes over. 4) Supporting compassionate practice. <p>The framework incorporated Connecting – recognising feelings – becoming motivated – taking action to help – sustaining relationships.</p>	<p>-Despite all participants finding the concept of compassion difficult to define, common themes emerged such as emotional connection and empathy.</p> <p>-The authors recognised that although the overall sample size was good the number of each stakeholder group was fairly small. This therefore could compromise generalisability.</p>
Papadopoulos et al (2016)	To explore nurses views and experiences of compassion at an international level and across nursing roles.	<p>-Exploratory cross-sectional descriptive study.</p> <p>-Online Survey</p> <p>-n=1323</p> <p>-15 Participating countries</p>	<p>-Majority of participants (59.5%) defined compassion in line with 'being moved by suffering and a wish to alleviate'. However, definitions varied by country.</p> <p>-59.6% argued compassion could be taught, however only 26.8% reported correct and adequate</p>	<p>-Online questionnaire designed by the author, therefore author and self-report bias may exist.</p> <p>-Standard definition was recognised by many participants however</p>

			<p>training was provided. With a significant relationship being found between nurses experiences of compassion and their views of its teaching.</p> <p>-4.5% noted receiving compassion from their managers.</p>	<p>variations were noted due to cultural and socio-political variations although not fully discussed.</p> <p>-Suggestion that compassion is not adequately taught / addressed in training or by managers</p>
Perez-Bret et al (2016)	To explore and reflect on the definition of compassion and analyse the concepts encompassed by the term.	<p>-Systematic literature review through:</p> <p>-Database searches.</p> <p>-Selections of experts consulted to identify specific articles.</p> <p>-Snowball method</p> <p>-n-28 following application of inclusion and exclusion criteria.</p>	<p>-Compassion was identified as a sensitivity in order to understand suffering with a willingness to help, but was often difficult to understand,</p> <p>-Despite it being difficult to understand it was deemed to be a duty in a healthcare professionals daily work.</p>	<p>-The database search was narrowed to the terms 'compassion' and 'empathy' therefore papers may have been missed and other terms weren't applied.</p> <p>-Difficult to understand yet deemed a duty??</p>
Sinclair et al (2016)	To map the literature on compassion in clinical healthcare.	<p>- Scoping review</p> <p>- 8 databases</p> <p>- Grey literature</p> <p>- Inclusion – exploration of perceptions or interventions of compassionate care in clinical populations, healthcare professionals and healthcare students.</p>	<p>- 6 themes:</p> <p>Nature of compassion</p> <p>Development of compassion</p> <p>Interpersonal factors</p> <p>Action and practical compassion</p> <p>Barriers and enablers</p> <p>Outcomes of compassion</p> <p>- Difficulties in defining and understanding compassion</p>	<p>- Lack of 'voice' noted for patient and family, however no reference made to healthcare professionals, and their experience (voice).</p> <p>- Deeper understanding of key behaviours and attitudes required.</p>

		<ul style="list-style-type: none"> - 2 reviewers – screened full-text articles and extracted study data. - Narrative approach to synthesising and mapping the literature used. -648 studies retrieved (44 included). 		
Self-Compassion				
Self-Compassion & Nursing				
Heffernan et al (2010)	Examines the relationship between self-compassion and emotional intelligence.	Descriptive correlational study (n=135) with nurses from 3 hospitals in New York.	<ul style="list-style-type: none"> -Positive correlation between self-compassion and emotional intelligence ($r=0.55$). -Further exploration of self-compassion and emotional intelligence in nursing is needed. -Identification of the benefits of enhancing self-compassion and emotional intelligence in nurses 	<ul style="list-style-type: none"> -Sample predominantly female (95.28%) -Study used SCS (Neff, 2003), which is questioned for its validity in research. -Results suggested that nurses have a high level of self-compassion then state additional ways to improve self-compassion are needed (contradicting).
Barnard & Curry (2011)	<p>Explores and reviews findings from personality, social and clinical psychology research related to self-compassion.</p> <p>Focused on the conceptualisations, correlates and</p>	-Literature Review	<ul style="list-style-type: none"> -Firstly defines self-compassion and distinguish it from other self-constructs such as self-esteem, self-pity and self-criticism. -Secondly reviews empirical work on the correlates of self-compassion, demonstrating that self-compassion has consistently 	<ul style="list-style-type: none"> -Literature review methodology unclear, with no cited inclusion or exclusion criteria. -Findings support a call for interventions to raise self-compassion.

	interventions of self-compassion.		been found to be related to wellbeing.	-‘overall there is a growing body of research that asserts that self-compassion is a construct that is distinct from other self-themes and is associated with psychological health.’
Reyes (2012)	Explores the concept of self-compassion using a modification of the evolutionary method (Rogers, 1989) in order to identify the antecedent, attributes and consequences.	Literature review (1979-2010). 74 articles retrieved (51 psychology, 8 religion, 3 nursing, 2 philosophy, 9 sociology and 1 management)	-Antecedent is viewed as suffering. -Attributes based on those identified by Neff (2003), self-kindness, awareness of common humanity, mindfulness and wisdom. -Self-compassion leads to a positive emotional response, consisting of increased autonomy, increased self-care capacity, and compassion for others. -In nursing practice self-compassion is often confused with caring.	-Disparity between psychology and nursing in terms of research in self-compassion. -Narrative approach to the literature review may impact upon rigour. -Self-compassion leading to self-care.
Gustin & Wagner (2013)	To explore participants understanding of self-compassion as a source to compassionate care in	Clinical Application Research / Action Research – using experiential / reflective	5 Core themes: 1- Being there with, and for self and others.	-Method unclear -Participants recruited on the basis of their wish to develop

	<p>order to develop a teaching – learning model that develops students ability to be compassionate towards self and others.</p>	<p>exercises with 4 clinical nursing teachers who volunteered to take part. They met four times (total 12 hours).</p> <p>Used phenomenological – hermeneutical method of analysis.</p>	<p>2- Respect for human vulnerability 3- Being non-judgemental 4- Giving voice to things needed to be said and heard. 5- Being able to accept the gift of compassion from others.</p> <p>Compassionate care needs to be mutually engaged in and was referred to as ‘the butterfly effect of caring’.</p>	<p>their own teaching and learning skills. -Although there was an ethical awareness, the study was not subject to an ethical application. -Particular model of suffering subscribed too (Eriksson).</p>
Senyuva et al (2013)	<p>Aims to analyse the correlation of self-compassion and emotional intelligence of nursing students.</p> <p>-What is the self-compassion of nursing students? -What is the emotional intelligence of nursing students? -Do the self-compassion and emotional intelligence of nursing students differ according to socio-demographic characteristics?</p>	<p>Descriptive correlational study with nursing students in Turkey (n=471).</p>	<p>-There is a correlation between self-compassion and emotional intelligence and that emotional intelligence, including the individual perceiving their emotions and using the knowledge they gained from them to function while directing thoughts, actions and professional applications, has positive contributions to the features of nurses with developed self-compassion.</p>	<p>-Use of the SCS, which has been criticised for its validity and scoring.</p> <p>-One nursing faculty only, therefore results may not be representative of the wider nursing population.</p> <p>-Results reported that nursing students do not qualify for the required levels of self-compassion (how is this level determined?) and emotional intelligence and that they could encounter communication problems in understanding the emotions</p>

	-What is the correlation of self-compassion and emotional intelligence of nursing students.			<p>of patients and their families during care giving.</p> <p>-Suggestion made to find ways to improve self-compassion.</p>
Mills et al (2014)	Exploring whether both self-care and self-compassion are viewed as selfish or essential for compassionate care.	Guest editorial: Narrative / opinion piece.	<p>-Dearth of literature available relating to self-care for nurses.</p> <p>-In the UK the importance of self-care is not evident within nursing guidance. This is also evident in other countries (New Zealand, Canada, the Philippines and Korea).</p> <p>-More self-compassion studies exist within the field of psychology.</p>	<p>-Highlights need for research within this field.</p> <p>-Opinion piece proposes self-compassion and self-care as essential.</p>
Zessin et al (2015)	<p>Examines the relationship between self-compassion and different forms of wellbeing.</p> <p>-How does self-compassion relate to different forms of wellbeing?</p> <p>-Are there any moderators that influence the</p>	Literature review – meta analysis (n=65). Initially 1433 articles of interest were found, 1269 immediately excluded due to self-compassion not being measured, no quantitative data being reported or no mention of wellbeing.	<p>-134 effect sizes were examined to determine the relationship between self-compassion and different forms of wellbeing.</p> <p>-Confirmed relationship between self-compassion and wellbeing.</p>	<p>-Lack of experimental research raises more questions.</p> <p>-Heterogeneous nature of the definitions of wellbeing.</p> <p>-Exact relationship between self-compassion and wellbeing unclear.</p>

	<p>relationship between self-compassion and different forms of wellbeing?</p> <p>-Is there a causal relationship between self-compassion and wellbeing?</p>	65 articles with 79 samples were included in the quantitative synthesis.		
Duarte et al (2016)	Aims to explore the relationship between nurses empathy, self-compassion and dimensions of professional quality of life.	<p>Cross-sectional design (n=280) with nurses in Portugal.</p> <p>Measures included: Professional Quality of Life Scale, Interpersonal Reactivity Index and the Self-compassion Scale.</p>	<p>-Compassion satisfaction was positively associated with empathic concern and higher levels of self-kindness, mindfulness and common humanity and lower levels of self-judgement and isolation.</p> <p>-Burnout was positively associated with personal distress and lower levels of the above characteristics.</p> <p>-Self-compassionate people are more able to regulate their emotions.</p>	<p>-Use of self-report measures particularly the SCS.</p> <p>-Authors note that other methods may alongside self-report measures may have been useful.</p>
Durkin et al (2016)	To measure associations between self-compassion, compassion fatigue, wellbeing and burnout in community nurses.	Cross sectional questionnaire study (n=37) with female (n=34) and male (n=3) community nurses.	<p>Community nurses who scored highly on measures of self-compassion and wellbeing, reported less burnout.</p> <p>Greater compassion satisfaction was also positively associated</p>	<p>Participants from different backgrounds may have differing levels of trait resilience.</p> <p>Single time point for data collection.</p>

			<p>with compassion for others and wellbeing.</p> <p>Self-compassion was negatively correlated to burnout ($r=0.369$).</p>	
Sinclair et al (2017)	Critically examines the construct of self-compassion to ascertain whether it is a variable, which mitigates work-related stress and promotes compassionate care giving.	Meta-narrative review of the literature (n=69)	<ul style="list-style-type: none"> -Construct has significant limitations. -Relates to compassion -Empirical studies used the SCS (Neff, 2003), which is heavily criticised for its validity. -Alleged outcome of the construct is compassionate care, however no studies report on this. -Self-compassion is not a construct in and of itself but rather is a composite of self-care 	<ul style="list-style-type: none"> -The construct is diminished in its clinical relevance and utility by the means it is explored (i.e. SCS). -Authors specified dearth of literature available exploring the impact of self-compassion and its link with compassionate care. -Unclear the extent of the limitations of the construct. -Need for an insight into the key behaviours and attitudes.
Self-Compassion & Clinical Populations				
Gilbert & Irons (2004)	1.To invite individuals attending a depression support group who also have co-morbid self-criticism to take part in a research project in order to investigate their inner self-critical and self-soothing processes.	<ul style="list-style-type: none"> -Pilot study -Sampled from individuals the authors had cared for over a number of years (n=8). -Met across four evening sessions (90 minutes), 3 weekly then 4 weeks later. 	<ul style="list-style-type: none"> -Participants felt their self-criticisms were automatic, powerful, intrusive, distressing and difficult to distract from. -Significant improvement in abilities to self-soothe. 	<ul style="list-style-type: none"> -No clear method provided. -Unclear whether this was based on compassion imagery or group processes. Indicates the importance of being with others / shared

	<p>2.Explore triggers and forms using a diary – focus on degree of intrusiveness and the power.</p> <p>3.Explore ability to generate and use compassionate imagery and obtain views of how this might be helpful.</p> <p>4.Explore the types of images generated.</p>	<p>-Diary recorded daily for two weeks then weekly.</p> <p>-Exploratory data – based on first three diary questions.</p>		<p>experience, in conjunction with self-compassion / compassion imagery.</p> <p>Future research to focus on further exploration of compassionate imagery and how to build this into an established psychotherapeutic approach – such as cognitive therapy.</p>
Neff et al (2005)	<p>Two studies examining the relationship between self-compassion, academic achievement goals and coping with perceived academic failure among undergraduate students.</p>	<p>Study 1 – Undergraduate educational psychology students (n=222), large southwestern university in the US.</p> <p>-Completed an anonymised survey questionnaire, measuring:</p> <ul style="list-style-type: none"> -Self-Compassion Scale (SCS) -Achievement goals -Fear of failure -Perceived competence -Intrinsic motivation -Anxiety -GPA 	<p>Study 1 – Found that self-compassion was positively associated with mastery goals and negatively associated with performance goals – a relationship that was mediated by the lesser fear of failure and greater perceived competence of self-compassionate individuals.</p> <p>Study 2 – Confirmed the above results amongst students who perceived their recent midterm grade as a failure, with results also indicating that self-compassion was positively associated with emotion-focused coping strategies and negatively</p>	<p>Studies suggest that self-compassion helps to facilitate the learning process by freeing individuals from the consequences of being self-critical. It also suggested freeing the individuals from isolation and over-identification with regard to failure. The results suggest self-compassion provides self-kindness, a sense of common humanity and an emotional balance.</p> <p>Results also highlighted that self-compassion is associated with lower levels of anxiety</p>

		<p>Study 2 – Undergraduate engineering and psychology students at two large urban universities (n=214).</p> <p>-Focused on reactions to perceived academic failure – data were only included from those highly dissatisfied with their recent midterm exam grade (n=110)</p> <p>-Measured:</p> <ul style="list-style-type: none"> -Grade satisfaction -Achievement goals -Perceived competence -Coping with failure 	<p>associated with avoidance-oriented strategies.</p>	<p>and proposed that individuals who are self-compassionate are more likely to adopt adaptive coping strategies. Although this relates to academic failure, the results provide a useful insight into the perceived benefits.</p> <p>The above focuses on the perceived benefits of learning to be self-compassionate and the resultant benefits. This may be interesting in terms of how nurses perceive it, in terms of seeking an emotional balance and more positive coping strategies.</p>
Gilbert & Proctor (2006)	<p>Explores patient acceptability, understanding, abilities to utilise and practice compassion focused processes and the effectiveness of Compassionate Mind Training (CMT) from an uncontrolled trial.</p> <p>Discusses the processes of shame and self-criticism</p>	<p>-Study involved patients with a severe and complex mental health difficulty (n=6) attending a day centre.</p> <p>-Acceptance into the group was based upon three clear criteria:</p> <ol style="list-style-type: none"> 1) The patients had to be in current therapy at the day centre and not be due 	<p>Results showed significant reductions in depression, anxiety, self-criticism, shame, inferiority and submissive behaviour.</p> <p>Improvements noted in the participants ability to be self-soothing, to focus on feelings of warmth and reassurance for the self.</p>	<p>-Originally 9 were recruited with 3 dropping out (clear rationale given, however may have been due to acceptability of the trial).</p> <p>-CMT useful for individuals with long-term conditions.</p> <p>-Provided a deeper understanding of shame, self-criticism and self – compassion.</p>

	and components of self-compassion.	<p>for discharge with the subsequent three months.</p> <p>2) They had to agree to attend regularly for a twelve-week period.</p> <p>3) There had to be issues with shame, self-criticism and self-devaluation.</p> <p>8 separate self-report questionnaires were used.</p>		<p>-Self-compassion components including the definitions by Neff (2003), evolutionary model and social mentality theory.</p>
Neff et al (2007)	Examined the relation of self-compassion to positive psychological health and the five-factor model of personality.	Correlational design with undergraduates (n=177)	<p>Self-compassion had a significant positive association with self-reported measures of happiness, optimism, positive affect, wisdom, personal initiative, curiosity and exploration, agreeableness, extraversion and conscientiousness.</p> <p>Significant negative association with negative affect and neuroticism.</p> <p>Self-compassion predicted significant variance in positive psychological health beyond that attributable to personality.</p>	<p>-Undergraduate discipline / subject not made clear.</p> <p>-Use of SCS</p> <p>-Significant limitation cited as correlational analysis can't determine if self-compassion causes or is caused by positive psychological traits or personality.</p> <p>-Recommendation to increase understanding of how to increase self-compassion amongst clinical and non-clinical populations.</p>

Mayhew & Gilbert (2008)	To explore the understanding, acceptance and value of Compassionate Mind Training (CMT) with individuals experiencing psychotic voice hearing.	<p>Case Series Design - with 7 individuals consented initially and only 3 completing.</p> <p>6 measures and a self-compassion diary administered at 3 time points (pre, post and 6 month follow up).</p> <p>CMT delivered by the authors individually over 12 sixty-minute sessions.</p>	<p>The results indicated benefits of CMT for the therapist and the patient (participant).</p> <p>The therapist was more able to access patients cognitions and emotions alongside increased therapeutic alliance.</p> <p>Participants acknowledged that they felt less threatened and safer.</p>	<p>CMT helps individuals to develop a more compassionate mind set focusing on developing the soothing system and focusing on the flow of compassion inwards and outwards. This resonates with a nurses role in providing compassionate care to others – but also highlights the need for self-compassion.</p> <p>Despite a small sample size there were perceived benefits to training the mind in compassion for both the therapist and the patient.</p>
Neff et al (2008)	To study levels of self-compassion in the US, Thailand and Taiwan.	<p>-All participants were undergraduate students. American (n=181), Thai (n=223) and Taiwanese (n=164).</p> <p>-Questionnaire study - SCS used</p>	<p>-Self-compassion significantly linked to wellbeing in all three cultures.</p> <p>-Highest levels of self-compassion found in Thailand and lowest in Taiwan.</p> <p>-Interdependence linked to self-compassion in Thailand only.</p>	<p>-Use of SCS as a sole measure and undergraduate student population. Therefore it is difficult to ascertain the generalizability of findings.</p> <p>-Highest levels of self-compassion in Thailand, which is highly associated with Buddhism.</p>

			-Independence linked to self-compassion in Taiwan and US.	
Pauley & McPherson (2010)	To explore the meaning and experiences of compassion and self-compassion for individuals with depression and anxiety.	<ul style="list-style-type: none"> -Interpretive Phenomenological Analysis (IPA) -Participants recruited from the clinical caseload of the researcher (n=10) -Participants needed a clinical diagnosis of Depression or Anxiety. -Semi structured interview. - 	<p>Three themes emerged:</p> <ol style="list-style-type: none"> 1) Compassion is a kind and active process: <ul style="list-style-type: none"> -Compassion is about being kind to people. -Compassion requires action. 2) Self-compassion is meaningful and useful: <ul style="list-style-type: none"> -Self-compassion feels meaningful for me. -Self-compassion might help me and my depression / anxiety. 3) Being self-compassionate is difficult: <ul style="list-style-type: none"> -I'm not sure I can be self-compassionate. -Negative impact of depression / anxiety on my ability to be self-compassionate. 	<ul style="list-style-type: none"> --Six participants had depression with three of the six also having anxiety. The other four had a specific phobia, which wasn't featured in the original inclusion criteria. -Summary sent back to participants added to rigour through member checking. -90% female sample. -Clients from researchers caseload, which may impact on the interaction during interview. -Individuals acknowledged the capacity for self-compassion but found it difficult to connect to.
Self-Compassion & Student Populations				
Neff (2003)	-Defines the construct of self-compassion.	-Pilot testing items for the SCS using undergraduate students at a large	-SCS demonstrates good construct validity.	-Self-compassion being viewed as a useful emotional regulation strategy.

	<p>-Describes the development of the Self-Compassion scale (SCS).</p>	<p>university (phase 1 n=68; phase 2 n=71).</p> <p>-Study 1 – scale construction with undergraduate educational psychology students (n=391). Administered with the self-compassion items generated during pilot testing. Intention to tap into self-kindness versus the self-judgement component of self-compassion. Responses assessed using exploratory factor analysis.</p> <p>-Study 2 – questionnaire study using the SCS at 2 time points with undergraduate educational psychology students (n=232).</p> <p>-Study 3 – Further examine the construct validity of the SCS with two groups which theoretically have</p>	<p>-The study reported that women had significantly less self-compassion than men. This was often due to higher engagement in self-judgement.</p> <p>-Self-compassion had a significant negative correlation with anxiety, depression and perfectionism.</p> <p>-Good test-retest reliability, across time 1 and 2.</p> <p>-Self-compassion was moderately correlated with self-esteem.</p>	<p>-Pilot test – type of students other than undergraduate not determined.</p> <p>-No gender differences found within the sample of Buddhists. Therefore suggesting that meditation practice and exposure to Buddhist teachings might be a useful way of achieving greater wellbeing and positive mental health.</p> <p>-Emotional awareness is required in order to realise whether an individual is self-compassionate or not.</p>
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		differing levels of self-compassion. The data from study 2 were compared with new data collected from a sample of Buddhists (n=43).		
Gilbert & Proctor (2006)	<p>-The paper presents an overview of the role of shame and self-criticism in psychological difficulties.</p> <p>-Then explores patient acceptability, understanding and the ability to understand and utilise compassion-focused practices.</p>	<p>-Patients recruited from an outpatient / day patient department for people with major / severe long term and complex psychological difficulties (n=6)</p> <p>-Acceptance into the research group depended on being open to the treatment service, not due for discharge, in regular attendance for 12 weeks and to have clear difficulties with shame, self-criticism and self-evaluation.</p> <p>-Measures used: Weekly compassion diary FSCS HADS (Depression and Anxiety Scale) FSCRS</p>	<p>Results showed significant reductions in depression, anxiety, self-criticism, shame, inferiority and submissive behaviour.</p> <p>Significant increase in the ability to be self-soothing and the ability to be able to focus on feelings of worth and reassurance for the self.</p>	<p>A compassion-focused approach can be useful for complex mental health difficulties, in switching from self-critical to self-soothing practices.</p> <p>The ability to be self-compassionate through training the mind to be compassion focused could be translatable to the healthcare setting.</p>

		Social Comparison Scale OAS Submissive Behaviour Scale		
Leary et al (2007)	Five studies investigating the cognitive and emotional processes by which self-compassionate people deal with unpleasant life events.	<p>-Students in all five studies were undergraduate psychology students.</p> <p>Study 1 – (n=117)</p> <p>-SCS</p> <p>-Recall unpleasant events</p> <p>-Using hierarchical linear modelling.</p> <p>Study 2- (n=123)</p> <p>-SCS</p> <p>-Self Esteem Inventory</p> <p>-Narcissistic Personality Inventory</p> <p>Study 3- (n=66)</p> <p>-SCS</p> <p>-Self Esteem Inventory</p> <p>-Video Introduction</p> <p>-Feedback Manipulation</p>	<p>Study 1- Self-compassion was negatively related to negative feelings (anxiety, sadness, self-conscious emotions)</p> <p>-Self-compassion was associated with keeping things in perspective.</p> <p>Study 2 – Self-compassion was also associated with less extreme behavioural inclinations in response to the imagined events.</p> <p>Study 3- Self-compassion buffers against the psychological impact of negative events.</p> <p>-Maintaining a degree of mindful psychological distance from one's emotions may temper emotional reactions.</p> <p>-Self-compassion may be beneficial when coping with negative interpersonal events, and a self-compassionate mindset may be particularly important for people with low self-esteem.</p>	<p>-Use of SCS throughout brings into question validity.</p> <p>-Self-compassion buffers people against the impact of negative events.</p> <p>-All five studies in a single paper made it difficult to navigate and read, in order to extract the main themes.</p> <p>-The benefits to self-compassion were clear, however this was with a sample of psychology undergraduates who were taking part for course credit. This therefore brings into question the generalisability of findings.</p>

		<p>Study 4- (n=103) -SCS -Video of them performing awkward or embarrassing task.</p> <p>Study 5- (n=115) -Describe a difficult event</p>	<p>Study 4- People low in self-compassion evaluated less favourably. -Self-compassion is distinct from more general feelings of compassion toward others.</p> <p>Study 5- In self-compassion condition lower negative affect was reported.</p>	
Neff & McGehee (2010)	Examines self-compassion and psychological resilience among adolescents and young adults.	<p>-Questionnaire study -Quantitative data only -Adolescents from a private high school in the US (n=235) -Young adults from a college in the same city (n=287). Measures used: SCS Beck Depression Inventory State Trait Anxiety Inventory Social Connectedness Scale Family Messages Measure Index of Family Relations Relationship Questionnaire</p>	<p>Self-compassion strongly associated with wellbeing in both adolescents and young adults.</p> <p>Family and cognitive factors identified as predictors of individual differences in self-compassion.</p>	<p>Self-compassion may be an effective intervention for young people suffering from negative self-views.</p> <p>No differences found between the adolescents and the young adults.</p> <p>Links discussed between attachment and early life experience and the development of self-compassion. May indicate the importance of early key messages and experience.</p> <p>Further studies needed to gain a better understanding of</p>

		New Personal Fable Scale		how self-compassion relates to functioning.
Zabelina & Robinson (2010)	To explore the potential utility of self-compassion in alleviating the self-critical tendencies that can undermine creative expression.	<p>-Undergraduate psychology students from a university in the US (n=86).</p> <p>-Mean age 20 yrs.</p> <p>-Measure used: Abbreviated Torrence Test for Adults (ATTA).</p> <p>-Control condition or Intervention using compassion focused approach.</p>	Self-judgemental individuals displayed lower levels of creative originality in the control condition but equal levels in the self-compassion condition.	<p>-Self-compassionate mind set was considered to be beneficial to optimal functioning.</p> <p>-Objectively scored as opposed to self-report.</p> <p>-Self-compassion is viewed as increasing creativity and functioning, therefore may be beneficial to other behaviours that are impeded by self-criticism.</p>
Beaumont et al (2016)	Explores the relationship between self-compassion, burnout, compassion fatigue, self-judgement, self-kindness, compassion for others and professional quality of life and the wellbeing of student midwives.	<p>A quantitative survey using a purposive and convenience sample (n=103)</p> <p>Using Pearson's correlations</p>	<p>Results suggested that student midwives who report greater compassion satisfaction, encounter better wellbeing, greater self-compassion, fewer symptoms of burnout and experience less compassion fatigue.</p> <p>When self-judgement scores were high student midwives reported less compassion for others, lower levels of compassion for the self, increased burnout, increased</p>	<p>-All female sample</p> <p>-Data gathered from one institution and a single time point.</p> <p>-Suggestion by the authors that mixed methods may have provided richer data.</p> <p>-Unsure when measure was given out other than at some point during the second year of training.</p>

			compassion fatigue and lower personal wellbeing.	
Campion & Glover (2016)	Aims to complete a qualitative exploration of responses to self-compassion in a non-clinical sample.	<p>Mixed methods were used to investigate the effects of learning about self-compassion through a video and imagery exercise.</p> <p>Semi-structured interviews were used followed by thematic analysis (Braun & Clarke, 2006).</p> <p>A convenience sample was recruited from a university student population (n=12).</p>	<p>3 Main themes emerged:</p> <ol style="list-style-type: none"> 1) Benefits of self-compassion. 2) Being self-compassionate. 3) Barriers to self-compassion. <p>A suggestion emerged that society needed to permit self-compassion first.</p>	<p>-All participants were female and were staff or postgraduate students.</p> <p>-Findings generalisable to a healthcare setting.</p>
Self-Care				
Jacobs (1990)	Considers the major concepts of Orem's Self-care Model in relation to the intensive therapy unit and explores the benefits	Narrative paper	The possibilities of achieving self-care for the critically ill population are limited, however the model encourages individualised care and heightens	Narrative paper, however explores the use of the model and presents some interesting ideas.

	and difficulties of applying the model in this area.		awareness of the patient as a whole.	
Davidhizar (1993)	Explores self-care options available to nurses working with patients with long term conditions.	Narrative	<p>-Specifically focuses on using Orem's conceptual model as a framework for self-care, and Mentoring.</p> <p>-Orem's conceptual model is discussed as a means of helping nurses cope with stressors and mentoring is proposed as a strategy for personal growth.</p>	<p>Suggestion to use both Orem's model and mentoring to enable the reduction of stress and enhance ability and growth.</p> <p>Narrative proposing two ideas as a means of nurses caring for themselves within a particular setting (long term conditions), however the ideas would be transferable into other nursing environments and settings.</p>
Mehta (1993)	Applies Orem's Self-Care Model to the nursing care of a hypothetical client (an elderly woman with a hip fracture) in order to explore its usability.	Narrative paper using a hypothetical case study.	Would prove useful and have a positive impact on client care.	Hypothetical narrative paper and based on author opinion.
Thorne et al (2003)	Explores self-care decision making in the management of type 2 diabetes and how this is learned and experienced.	<p>Qualitative descriptive approach.</p> <p>Secondary analysis of two data sets from two primary studies looking at</p>	<p>-Results showed an overarching theme of the 'Decision to resume control' with themes linking to it:</p> <p>-Experiencing the disease.</p> <p>-Managing the social context.</p> <p>-Managing lifestyle.</p>	Self-care appears to be a complex developmental process with multiple phases moving through disease trajectory, healthcare culture

		<p>expertise in self-care decision making. Data set 1 (n=22), data set 2 (n=21).</p> <p>Inclusion included the need for several years experience in self-care decision making; an ability to communicate in English and to effective in their self-care behaviours.</p>	<ul style="list-style-type: none"> -Managing treatment. -Managing healthcare. -Envisioning futures. 	<p>and aiming for a uniquely meaningful life.</p> <p>The ability to assume control is deemed important but in order to do this, participants needed to move through a number of elements. This could lead to the idea that self-care is perceived as a complex concept.</p>
Newbould et al (2006)	Clarification of what is known about self-care in chronic illness and the impact of lay-led self-management programmes.	Literature review, with 17 articles of interest and 2 conference papers.	<p>Despite potential benefits, problems were cited such as the overstatement of evidence and the varied experiences of what patients think and do.</p> <p>The existing evidence base suggested self-management as providing short term benefits.</p>	-Specifically focused on lay-led interventions in the USA, targeting a specific programme known as EPP. This may have led to data and literature being missed.
Rose & Glass (2006)	Research study exploring emotional wellbeing and professional nursing practice. It also explores the relationship between mental health nursing, emotional wellbeing and a nurses capacity to nurse in	<ul style="list-style-type: none"> -Critical feminist methodology -Emancipatory framework -Semi-structured interviews with female mental health nurses (n=5) in Queensland. 	<p>Four interrelated components appeared within the meaning of emotional wellbeing:</p> <ul style="list-style-type: none"> -nebulous notion -The stress relationship -The mind, body, spirit connection -Inner sense of balance. 	<ul style="list-style-type: none"> -Nurses required a greater need for support in their practice. -In order to maintain a passion for nursing there was a need for organisational support. -Nurse / patient relationships are described as emotional

	a satisfying and professional way.	-Years experience between 8 and 30 years. -Purposive and snowball sampling used.	Professional practice themes: -Being able to speak out (or not) -Being autonomous (or not) -Being satisfied (or not)	and there is a need for both proactive and reactive processes from an organisational perspective (focus is on organisation rather than the self). -Exclusively sampled mental health nurses. -No limitations reported.
Wilkinson & Whitehead (2009)	Explores the development of the concept of self-care through health related literature and reviews the factors that have shaped the concept.	Literature review (n=22)	Many definitions of self-care exist , however a consensual definition has not been reached. The concept has been shaped by different social, economic and political factors and appears to be embedded in diverse, theoretical perspectives and paradigms.	Successful self-care will be facilitated through a shift from feeling responsible for patients to feeling responsible to patients. Appears patient facing focused.
Richard & Shea (2011)	To delineate five concepts often used within nursing and healthcare literature: Self-care, self-management, symptom management and self-efficacy (in self-care).	-Literature Review of 65 articles, book chapters and books using the following three steps: -Review of the literature for each concept. -Identify relationships between concepts. -Identify commonalities and differences.	All concepts were identified as different however were encompassed within the term of self-care. The attribute of awareness was common across all five concepts.	Self-care held very general definitions within the literature and appears to be an umbrella term for the other concepts, however each term had its own distinct features. Again suggests that self –care is a complex term, which is multi-faceted.

Richards (2013)	Discusses self-care as a life long journey and as an expectation as part of the professional role of a nurse alongside caring for patients.	Narrative	<ul style="list-style-type: none"> -Defines self-care -Places a focus on the role and influence of a nurse leader. -Dual process of caring for the self and others. 	<ul style="list-style-type: none"> -Narrative piece, which holds some interesting ideas, however these aren't evidence based. -The dual process of caring for self alongside another is stated as important and part of the nursing role (again an opinion).
Webber et al (2013)	Discusses self-care definitions within the context of the current literature / evidence base.	Narrative	<ul style="list-style-type: none"> -Definitions of self-care in health are broad and encompass disease prevention and individual choice in changing lifestyle behaviours. -Definitions aimed at healthcare policy need to be more comprehensive, explicit and instructive. 	<ul style="list-style-type: none"> -Although a narrative this paper suggests the complexity of self-care from an individual and a healthcare policy perspective. -It also provides an overview of existing definitions. -The author suggests further exploration through research of self-care definitions and its utility with self-care behaviours.
Salloum et al (2015)	Examines the role of Trauma Informed Self-Care (TISC) on compassion satisfaction, burnout and secondary trauma.	<ul style="list-style-type: none"> -Questionnaire study -Child welfare workers and supervisors recruited from a child welfare 	<ul style="list-style-type: none"> -Child welfare workers are at risk of negative emotional outcomes including burnout and secondary trauma. 	<ul style="list-style-type: none"> -The authors used an unvalidated questionnaire and also recognised that they did not adequately examine self-care as a construct in the

		<p>organisation in Florida (n=104).</p> <p>-Measures used:</p> <p>-ProQol</p> <p>-TISC (designed by authors)</p>	<p>-Higher levels of burnout and lower levels of compassion satisfaction in those individuals with more than a years experience.</p> <p>-Greater levels of TISC associated with lower levels of burnout and higher levels of compassion satisfaction.</p>	<p>literature prior to the development of the questionnaire or the study.</p> <p>-Highlights a need to examine the construct of the concepts under study prior to embarking on a study.</p> <p>-Despite the limitations the results still show the potential benefit of a self-care intervention on worker wellbeing.</p>
Zahniser et al (2017)	To study the role of self-care in clinical psychology graduate training.	<p>Questionnaire study (n=358). Graduate students from APA accredited doctoral programs in clinical psychology across the US.</p> <p>Used four validated questionnaires exploring self-care, perceived stress, affect and wellbeing.</p> <p>Used demographic data and two brief measured formulated for the purpose of the study to measure, self-care culture and perceived progress.</p>	<p>Self-care is associated with greater personal wellbeing and self-reported progress.</p> <p>Self-care can serve as a buffer against the harmful effects of stress.</p> <p>Two important aspects of self-care were building professional support systems and self-awareness of one's needs and reactions to stressors.</p> <p>Main points:</p> <ol style="list-style-type: none"> 1) Self-care strategies in areas of professional support and cognitive 	<p>Method not clear.</p> <p>Good acknowledgement of limitations, including sample (primarily clinical psychology students) and self-report data. Sample disproportionately comprised of PhD students, which may impact generalizability.</p> <p>A focus is placed on support and self-awareness.</p>

			<p>awareness are especially helpful.</p> <p>2) Programs can help foster self-care among students by emphasising its importance and creating a supportive and collaborative climate within the program.</p> <p>3) Programs should take concrete steps to help develop and teach self-care skills, including formal instruction and role modelling.</p>	
Supervision				
Lyth (2000)	Develops a conceptual analysis of clinical supervision – using a method developed by Rogers (1989).	-Narrative literature review	<p>-Clarification of the term clinical supervision is difficult and varies between practice settings.</p> <p>-Cited as important due to potential benefits for patient care and the nurses themselves.</p>	<p>-No clear literature review methodology cited.</p> <p>-There is a need for nurses to have a clear understanding of the term if they are to actively engage in the process of clinical supervision.</p>
Edwards et al (2005)	Reports findings from a study, which aimed to identify factors that may influence effectiveness of	<p>-Descriptive quantitative survey</p> <p>-Recruited mental health nurses in Wales across 11 trusts (n=260).</p>	<p>-Questionnaire data not normally distributed. Total scores used.</p> <p>-Clinical supervision sessions that were longer than 60 minutes were considered more beneficial</p>	-Although large sample this was a response rate of only 32%.

	clinical supervision for mental health nurses.	<ul style="list-style-type: none"> -Measures: -The Manchester Clinical Supervision Scale (MCSS) 	<ul style="list-style-type: none"> and needed to occur at least monthly. -Good rapport with the supervisor was essential as was being given a choice of supervisor. -Barriers included lack of suitable accommodation and a fear of being interrupted. 	<ul style="list-style-type: none"> -Time, space, choice and rapport were important factors. -Short and infrequent supervision sessions were seen to be of limited value.
White & Winstanley (2010)	Reports on selected findings from an RCT conducted with mental health clinicians in Australia, to try and establish an evidence base for causal relationships with quality of care and patient outcomes, in order to inform mental health nursing and practice development.	<ul style="list-style-type: none"> -Reports findings from four large-scale clinical supervision (CS) research studies. -Secondary analysis (quantitative) -17 mental health facilities (within 9 participating locations). -Researchers were blind as to how the locations for the clinical supervision intervention were chosen. -24 nurses were trained to be Clinical supervisors in the context of the RCT. -Mixed methods were utilised. -Measures: General Health Questionnaire Manchester Clinical Supervision Scale 	<ul style="list-style-type: none"> -Quantitative findings supported the premise that CS training had sustainable benefits. -Individual performance of clinical supervisors may have been impacted upon by organisational culture. <i>'Good clinical supervisors may have been as unlikely to achieve a desired effect in unhealthy cultures, as were poor clinical supervisors in healthy cultures'</i> (p161). -9 Substantive themes (suspiciousness, staff commitment, context for non involvement, culture, burden / costs, roster, size, continuation of CS, recruitment and retention). 	<ul style="list-style-type: none"> -No clear method cited for thematic analysis. <i>'Policy discussion about whether mental health nurses change because they see the light (the theoretical basis for CS remaining an opt in activity) or because they feel the heat (the basis for CS to become mandatory).'</i> (p162) -Need for a focus on the person and the environment and questions how engagement can most successfully occur.

		<p>Maslach Burnout Inventory Short Form Health Survey Nursing Work Index Mental Health Problems Perceptions Questionnaire. -Given out at baseline and after 12 months. Qualitative – Semi structured interviews and personal diary accounts (n=17). -Thematic Analysis</p>		
Koivu et al (2012)	<p>Aims to identify which nurses benefitted most from Clinical Supervision (CS) and to explore whether those who attended were healthier and more satisfied with their work than their peers who didn't.</p>	<p>-Questionnaire study in. -Findings taken from a CS programme implemented between 2004-2006. -19 CS groups implemented on 14 medical and surgical inpatient and outpatient units. -Open to anyone interested. -Provided in groups of 4-8 -90 minute sessions every 3-4 weeks over 1-3 years. -Measures: Finnish version of MSS QPS Nordic</p>	<p>-Nurses who engaged in CS perceived more control at work and a higher level of commitment to the organisation than those nurses who didn't. -The nurses who engaged also reported fewer symptoms of burnout. -Both groups reported the same level of high job demands, exhaustion and cynicism.</p>	<p>-Male nurses excluded due to minor participation in CS (n=3). This number is interesting as the original recruitment phase approached 304 nurses. -Other demographics not reported.</p>

		<p>GHQ-12 MBI-GS</p> <p>-Female nurses (n=148)</p> <p>-Nurses who did not attend made the comparison group.</p>		
MacLaren et al (2016)	<p>Explore emotion cultures constructed in supervision and to consider how supervision may function as an emotionally safe space and promote the opportunity for critical reflection.</p>	<p>-Review of the literature between 1995-2015.</p> <p>-Narrative Inquiry approach with mental health nurses (n=8).</p> <p>-One male in the sample.</p> <p>-Semi-structured interviews.</p> <p>-Interviews lasted between 60-90 minutes.</p>	<p>-Literature review suggested the positive impact of supervision on a nurses wellbeing, however processes and the interaction of emotions are unclear.</p> <p>-3 Distinct feeling rules emerged: Safety and reflexivity Staying professional Managing feelings</p> <p>-In additions 2 organisational feeling rules emerged: Being Stoical Inferiority.</p> <p><i>'The transition between cultures and sets of feeling rules was not simple and the nurses narratives suggest that it depended on a range of practical and relational factors.'</i> (p2430)</p>	<p>-Gender bias</p> <p>-Small sample with several holding an interest in supervision through their work in psychological therapies (self-selecting).</p> <p>-Contrast between feeling rules in supervision and in the organisational culture.</p> <p>-Resonates with feeling states and emotions in 'emotional labour'.</p>

Schwartz Rounds				
Goodrich (2016)	Explores findings from 21 Schwartz Rounds exploring the question 'what makes a compassionate relationship between a caregiver and patient?'	<ul style="list-style-type: none"> -Members of the Schwartz community were invited to take part in a national conversation answering the aforementioned question. -21 groups were run in 2015 -Thematic Analysis 	Themes: 1) What is compassion? How is it demonstrated? 2) How is compassion achieved? 3) Can we teach compassion? 4) Barriers to compassion 5) What can help compassion?	-Discussion around compassion fatigue and strategies to physically and emotionally protect the self.
Mindfulness				
Pipe et al (2009)	To evaluate a brief stress management intervention for nurse leaders.	<ul style="list-style-type: none"> -RCT -Nurse Leaders (n=33) -Randomly assigned to brief mindfulness meditation course or a leadership course. -Self-report measures: Symptom Checklist Positive Symptom Distress Index Global Severity Index -Administered at baseline and within 1 week of course completion. 	<ul style="list-style-type: none"> -Results support effectiveness of mindfulness in reducing self-reported stress. -Significant improvement on positive symptom distress index and global severity index. 	<ul style="list-style-type: none"> -Further follow up data would have been useful to assess whether improvements were short term or longer-term changes. -Nurse leaders who are more self-aware and who are able to self-reflect are more effective in caring for their staff team, including helping with stress reduction.

Cunningham et al (2013)	Exploration and review of an interdisciplinary program called Mindfulness Based Stress Reduction (MBSR).	-Narrative Discussion piece, exploring nurses experiences of attending a one hour session each week of MBSR.	-Managers cover the ward whilst staff attend. -The program is occurring at the unit level placing bedside nursing leadership at the helm. -Aimed at ground floor staff. Not intended to exclude managers but may be seen to improve relationships. -Billed as changing the face of self-care for nurses.	-Discussion piece -Further qualitative exploration would be useful to determine accessibility and acceptability alongside experience. -Authors advise further exploration and research using mindfulness and self-care intervention.
Resilience				
Jackson et al (2007)	Explores the concept of personal resilience as a strategy for responding to adversity in the workplace and in order to help identify strategies to enhance a nurses personal resilience.	-Literature review (1996-2006) -76 papers reviewed	-Question of whether resilience is innate or learned. -Belief from the review is that it can be strengthened through the development of personal strategies. -Hardiness can be learned. -Self-development strategies proposed: Building positive nurturing professional relationships and networks. Maintaining positivity. Developing emotional insight. Achieving life balance and spirituality. -Becoming more reflective.	-Qualitative research recommended. -Suggest exploration of <i>'innovative ways of nurturing and supporting nurses so that they are better able to thrive and sustain satisfying careers even in the contexts of organisational difficulty and workplace adversity.'</i> (p7).

McCallister & McKinnon (2009)	Discusses resilience and the application of resilience research to nursing education.	-Narrative literature review	-Recommend: Identity building work Coping, capacity and strength development. Learning leadership for change.	-No clear methodology stated. <i>'Emphasis on resilience and related qualities in higher educational programs could assist individuals and professional groups to thrive in busy, dynamic workplaces and attain healthy professional self-identities, relevant professional competence and public esteem.'</i> (p377)
Delgado et al (2017)	To investigate the knowledge base related to resilience in the context of emotional labour in nursing.	-Integrative literature review -2005-2015 -27 qualitative and quantitative articles appraised using the mixed methods appraisal tool.	-The emotional dissonance experienced through surface acting can be viewed as workplace adversity and lead to stress and burnout. -Without both internal and external protective factors or resources nurses overall wellbeing can be affected, alongside professional practice and the core day to day nursing work.	-Limited to literature over the past 10 years. -Resilience can increase nurses internal resources,

Compassionate Care				
Koerner (1995)	To look at compassion as the essence of nursing.	Narrative paper	A compassionate stance will help construct a new way of approaching colleagues.	<ul style="list-style-type: none"> -Narrative -Focus on colleagues, rather than patient or self. -States importance of engagement and action.
Tuckett (1998)	Explores concepts of virtue theory, utilitarianism and deontology in outlining a conceptual framework for nurses in practice.	<ul style="list-style-type: none"> -Moebius framework -Narrative 	<i>'the nurse ought to respond with a sense of compassion that befits the moment rather than adhere to a rule at all costs.'</i> (p220)	<ul style="list-style-type: none"> -The article was difficult to read. -This could tie to emotional labour and the adherence to display rules of an organisation.
Von Dietz & Orb (2000)	Focuses on the concept of compassion and its meaning for nursing practice.	Narrative paper	Compassionate approach is an integral component of nursing care.	<ul style="list-style-type: none"> -Narrative -Propose that compassion is not just an emotional connection but also rather a morale virtue.
Darren-Thompson & Ciechanowski (2003)	Explore an understanding of the patient-physician relationship in family practice.	<ul style="list-style-type: none"> -Literature Review -35 articles of interest 	<ul style="list-style-type: none"> -Attachment Theory highlights importance of patient-physician relationship. -Innate need to form strong attachment bonds to their earliest caregivers. 	<ul style="list-style-type: none"> -A deeper understanding of the role of attachment is needed. -No limitations cited

			-Physicians can more readily adopt an understanding, compassionate and flexible treatment stance by recognising attachment relationship patterns, thus improving medical treatment outcomes.	-9 further articles were located but were excluded due to not being available in English.
Shantz (2007)	Explores the concept of compassion.	Literature review (2004-2005)	<p>-426 articles identified with only 1 containing the word compassion in its title.</p> <p>-Concept / term used interchangeably with caring, sympathy and empathy.</p> <p><i>'As a human being, many a nurse will say that it was compassion for others that inspired her to become a nurse. Yet to claim ownership to the virtue of compassion, it is necessary first of all to identify, understand and internalise its profound meaning.'</i> (p54)</p>	<p>-Literature only searched between 2004-2005, however rationale for this not provided.</p> <p>-Term is often used interchangeably, therefore there is a need to understand how compassion is experienced and understood by nurses.</p>
Bramley & Matiti (2014)	To understand how patients experience compassion within nursing care and explore their perceptions of developing compassionate nurses.	<p>-Qualitative exploratory descriptive approach (n=10)</p> <p>-Male (n=5), female (n=5), aged 18-91.</p> <p>-Used semi-structured interviews.</p>	<p>3 themes:</p> <ol style="list-style-type: none"> 1) What is compassion: knowing me and giving me your time. 2) Understanding the impact of compassion: how it feels in my shoes. 	<p>-Can compassion be taught or remain a moral virtue.</p> <p>-Varied sample – (n=9 had 4-10 day stay, n-1 had an 8 week stay)</p>

			Being more compassionate: communication and the essence of nursing.	
Bray et al (2014)	Exploring qualified health professionals and nursing students understanding of compassion and the role of health professional education in promoting compassionate care.	<ul style="list-style-type: none"> -Mixed methods. -Explanatory design. -Quantitative data collected first using a survey / likert scale (n=352) – 44.2% response rate. -Qualified staff (Nurses and AHP's n=155) -Students (n=197) -Aged 18-40 -77.8% female -Qualitative data then gathered using semi-structured interviews (face to face or telephone) (n=14) – 7 students and 7 qualified. -Participants recruited through a university in the North West of England. 	<ul style="list-style-type: none"> -2 main themes: Compassion vs knowledge Learning, developing and teaching compassion. -Findings indicate a high level of consensus in relation to participants understanding of compassion in healthcare. -Participants had inconsistent perceptions about the role of education in compassionate practice. 	<ul style="list-style-type: none"> -The survey was developed by authors and reflected issues from the literature. -30 initially showed an interest in being interviewed however 16 were excluded due to illegible contact details, difficulties in availability and withdrawing interest. -Ambiguity as to whether compassion can be taught or learnt. -Strong impact of practice environment. -Essential those professional values which include care and compassion are central to nurse education.
Crawford et al (2014)	Exploration of the language of compassion in acute mental health care.	<ul style="list-style-type: none"> -Mixed Methods (Corpus assisted discourse analysis). -2 mental health units within 1 trust. 	<ul style="list-style-type: none"> -Little description of compassion despite that being the topic of focus. <i>'language indicated both an institutional mentality and</i> 	<ul style="list-style-type: none"> -Authors cited small numbers of participants. -Clear difficulty in articulating compassion.

		<p>-20 practitioners interviewed (2 psychiatrists, 2 ward managers, 2 ward sisters, 8 staff nurses, 1 3rd year student nurse & 5 healthcare assistants).</p> <p>-Same interviewer.</p> <p>-Interviews lasted between 20-30 minutes.</p> <p>-Examined the words and phrases.</p>	<p><i>emotional distancing between practitioners and patients, despite concern for delivering a quality service.'</i> (p725)</p> <p>-Production line mentality approach to care delivery.</p>	<p>-Future research focus recommended to focus on how organisational, environmental and process changes may go some way to promote compassionate care.</p>
Dewar et al (2014)	<p>Aims to discuss the meaning of compassionate care and how it applies to staff, patients and their families within a social care and health setting.</p> <p>It also aims to look at its application in practice and how organisational infrastructures can affect care delivery.</p>	<p>-Discussion paper using data from the leadership in compassionate care programme 2007-2011. This was an action research programme.</p> <p>-Literature search (1999-2011) – focusing on compassionate care and person-centred care.</p> <p>-Mixed methods for leadership programme: Narrative accounts of care (n=234) Informal observations of practice (n=52) Focus groups (n=319)</p>	<p><i>'Compassion is a skilled interpersonal and relational process from which staff can gain energy and satisfaction.'</i> (p1745)</p> <p>-Suggested that if supported these skills can be embedded and developed if there is a focus on supporting development in the context of relationships.</p>	<p>-No clear methodology for literature review.</p> <p>-Large data set.</p> <p>-Key implications for practice.</p>

		<p>Photo elicitation processes (n=269) Interviews with staff (n=140).</p> <p>-Data analysed using immersion crystallisation and constant comparative methods over a 3 year period.</p>		
Muncer et al (2015)	Assessing the psychometric properties of a questionnaire aimed at measuring compassionate care.	<p>-Schwartz Center developed 16 criteria to assess compassionate care in 1998.</p> <p>-Developed by a 20-member committee with diverse viewpoints and experience.</p> <p>-These items were combined with data from 5 focus groups (2 patients, 2 physicians and 1 nurses) conducted in 2010 to fine tune questions asked in the survey and developed the SCCCS.</p> <p>-Split sampling used (n=801) -recently hospitalised over previous 3 days.</p>	<p>-Scale demonstrates excellent reliability in measuring a patient's perception.</p> <p>-Urged the inclusion of compassionate care elements in national patient experience surveys.</p>	<p>-Large-scale study.</p> <p>-Further research recommended using the scale.</p> <p>-No further information related to the original committee members who developed the criteria.</p>

Richardson et al (2015)	<p>To undertake a discursive literature review focusing on caring, compassion and empathy.</p> <p>To understand the teaching and learning elements of these concepts and to design and implement a unit of study for undergraduates which address these concepts for student nurses.</p>	<p>-Discursive literature review.</p> <p>-Uses Muerzels model of therapeutic relationships.</p>	<p>-Caring, compassion and empathy and the therapeutic relationship can be taught.</p>	<p>-Literature review methodology unclear.</p>
Valizadeh et al (2016)	<p>Explore workplace and organisational barriers to compassionate care from a nurses perspective.</p>	<p>-Qualitative Exploratory Design</p> <p>-Conventional Content Analysis.</p> <p>-Nurses in Northwest Iran (N=15)</p> <p>-Nurses from different fields.</p> <p>-9 females and 6 males.</p>	<p>-Main theme: Unsupportive Organisational Culture.</p> <p>-Categories: Excessive workload alongside inadequate staffing. The lack of value on compassionate care.</p> <p>-Sub-categories: Time pressure Paperwork Overcrowded wards Conspicuous staff shortages Poor salaries Lack of appreciation or acknowledgement. Lack of professional education.</p>	<p>-Lack of generalisability due to small sample size from a single setting.</p> <p>-Suggestions for viewpoints from other healthcare providers.</p>

Tierney et al (2017a)	To explore and understand the meaning of compassionate care for healthcare professionals working with patients with Type 2 diabetes.	Grounded Theory Study using focus groups and individual interviews (n=36) Purposive sampling	How appraisal of a situation can impact upon compassionate care. How compassionate care is not solely innate but rather based on an individuals appraisal and the resources they possess in order to cope. Non-adherence can be viewed as a threat and impede compassionate care.	-Highlighted the importance of the impact of an environment on a healthcare professionals appraisal of a situation. -If a sense of risk predominates with a focus on output, this can lead to a 'production line mentality' and thus impede compassion
Tierney et al (2017b)	As above – 3 papers from same study. This paper explored how the flow of compassionate care is enabled.	As above	Compassionate care can be enhanced by defenders, such as a supportive environment with supportive colleagues, or depleted by drainers such as competing demands on time and resources.	-Presents a model of compassionate care based on flow. -Generalisability. -Based on perception rather than what occurred; however this is often the case in qualitative research using interviews and focus groups.
Compassion satisfaction				
DiBlasi et al (2001)	To determine empirical evidence to support that doctor-patient relationships are acknowledged as having an	-Systematic Literature Review. -2 Reviewers -25 RCT's identified with 12 studies providing	-Half of the studies found positive effects on patients health status after a manipulation of patient-practitioner relationships.	-The authors suggest both more quantitative and qualitative research.

	important therapeutic effect.	enough data for a meta-analysis. -Used 183 search terms.	-None of the studies examined the effects of emotional care. -There is a lack of attention to the more humane aspects of care.	-Interesting that the emotional element of the doctor-patient relationship was missing in the literature / data.
Laschinger et al (2009)	Explores the impact of professional practice, environment, workplace civility and empowerment on new graduate burnout.	-Tested a model derived from a review of the literature integrating theory and research. -Quantitative -Used data from a study conducted in the US in 2006 (n=3,180) -Further data from nurses who had been qualified for less than 2 years (n=247). -Used one measure: The Practice Environment Scale of the Nursing Work Index (NWI-PES).	-New graduates reported high levels of emotional exhaustion (EE). -Sub analysis revealed greater EE was associated with staffing inadequacy and a primary focus on the medical model. -Managerial strategies are needed to empower nurses for professional practice are needed to ensure nurses health and wellbeing. -Importance of creating positive work environments.	-The cross sectional nature of the original study precludes strong claims of causal effects. -Recommendation to include nurses with various degrees of experience. -Authors recommend a longitudinal study to explore changes over time. -In order to reduce burnout adequate nursing resources are required . -Professional practice environments also foster high quality collegial working relationships.
Utrainen & Kyngas (2009)	Explores nurses job satisfaction.	-Literature Review (1997-2006). -21 papers reviewed	-Factors influencing job satisfaction included: Interpersonal relationships Patient care Organising nursing work -Nurses job satisfaction is primarily ground in the perceived	-14 of the studies conducted in the US. -Identifies the need for both satisfaction when caring for patients and other aspects of nursing work.

			communal aspects of nursing work including interpersonal relationships, social interaction and communication with peers.	
Hooper et al (2010)	Explores the prevalence of compassion satisfaction, burnout and compassion fatigue among emergency nurses and nurses from three other areas.	<ul style="list-style-type: none"> -Exploratory study using a cross sectional, point in time survey. -Full time and part time registered nurses with more than 1 years experience (n=109). -1 Measure used: PROQoL. 	<ul style="list-style-type: none"> -82% of emergency nurses had moderate to high levels of burnout. -86% had moderate to high levels of compassion fatigue. -No difference between Emergency nurses and other nursing specialties. 	<ul style="list-style-type: none"> -Not clear what percentage of the sample were emergency nurses. -High level of female respondents. -Findings are limited to one acute hospital, therefore cannot be generalised to other areas or organisations. -Tendency to focus on stressors within an environment. -Interventions needed to help nurses maintain caring attitudes.
Cole-King & Gilbert (2011)	Outlines the development of an emerging new approach to compassion, acknowledging current barriers to the delivery of compassionate care.	-Narrative discussion.	<p><i>'In the absence of compassionate care people are frightened, upset, stressed, confused and even depressed.'</i> (p35)</p> <ul style="list-style-type: none"> -Claim that compassion makes interventions more clinically effective. 	<ul style="list-style-type: none"> -Discussion piece. <i>'By developing health care systems that facilitate compassionate care, our patients experiences and clinical outcomes will be better, our own risks of burnout or litigation will be less and our job satisfaction</i>

				<i>will be considerably greater.'</i> (p35).
Rossi et al (2012)	Aim is to assess burnout, compassion fatigue and compassion satisfaction among staff at 4 community based mental health services in Italy.	<p>-Quantitative using 2 measures: ProQol GHQ-12</p> <p>-311 staff approached, 84% response rate (n=260).</p>	<p>-Psychiatrists and social workers had the highest levels of burnout and compassion fatigue.</p> <p>-A higher level of compassion fatigue was associated with females and having had experienced one negative life event in the previous year.</p>	<p>-Given that the research was conducted across four sites results could be generalisable.</p> <p>-No information given related to groups of staff, therefore difficult to compare findings.</p>
Emotional labour				
Menzies Lyth (1960)	Explore new methods of completing tasks within a nursing organisation and looking at the functioning of social systems as a defence against accounting for the anxiety and stress chronic among nurses.	<p>-Large hospital site in London incorporating various sites.</p> <p>-Driven by a need to focus on training rather than constant staffing pressures for patient care – this led to training crisis.</p> <p>-Formal interviews (n=70) including individuals and groups.</p> <p>-Some observational data.</p>	<p>-Senior staff felt there was a danger of complete breakdown with the systems of allocation and practical work.</p> <p>-High level of tension, distress and anxiety amongst nurses.</p> <p>-<i>'Hard to understand how they could tolerate so much anxiety and indeed we found much evidence that they could not.'</i> (p97)</p> <p>-One third of students did not complete their training.</p>	<p>-How observational data was collected was unclear.</p> <p><i>'Nurses are confronted with the threat and the reality of suffering and death as few lay people are.'</i> (p98)</p> <p>-Reinforces high levels of distress that nurse face alongside growing pressures.</p> <p>-Given that the research was conducted many years ago, it is interesting that current research reflects similar findings.</p>

			<ul style="list-style-type: none"> -Change of jobs was frequent. -Sickness rates were high. -Dealing with patients and relatives and colleagues intensifies anxiety. <p>Main finding (p98): Defence mechanisms:</p> <ul style="list-style-type: none"> -Splitting up the nurse-patient relationship. -Depersonalisation, categorisation and denial of the significance of the individual -Detachment and denial of feelings. -The attempt to eliminate decisions by ritual task performance. -Reducing the weight of responsibility in decision making by checks and counter checks. -Collusive social redistribution of responsibility and irresponsibility. -The reduction of the impact of responsibility by delegation to superiors. -Idealisation and underestimation of personal developmental possibilities. -Avoidance of change. 	
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			<p>Social defence system:</p> <ul style="list-style-type: none"> -Threat of crisis and operational breakdown. -Excessive movement of student nurses. -Under employment of student nurses. -Deprivation of personal satisfactions. 	
Allan & Smith (2005)	Discusses the findings from case studies with six modern matrons and their emerging role and the relevance of emotional labour in understanding the role.	<ul style="list-style-type: none"> -Case study design (n=6) -Focus groups -Semi-structured interviews -Thematic and narrative analysis. 	<p>-Development of personal authority:</p> <ul style="list-style-type: none"> Emotion management Patient liaison Clinical leadership Nursing management. 	<p>-No information provided as to the experience of the participants.</p> <p>-The role provides the interface between the organisation, the professions and the patient.</p> <p>-Importance of leadership role.</p> <p>-Authority.</p>
Larson & Yao (2005)	Explore empathy and propose that physicians consider empathy as emotional labour.	<ul style="list-style-type: none"> -Narrative discussion -Presents a model of clinical empathy and describes the mechanisms involved. -Reviews the literature to explore the research of 	<p>-Emphasis should be focused on designing training programs and creation of a culture that values empathy in treatment.</p>	<p>-No clear methodology for the literature review.</p> <p>-Discussion piece.</p>

		emotional labour and acting methods. -Discussion around the value of learning about emotional labour and acting methods in creation of empathic treatment relationships.		
McCreight (2005)	To investigate nurses experiences and feelings in dealing with parents who have experienced a pregnancy loss.	-Qualitative -Semi-structured interviews -Nurses from Gynaecological units (n=14).	-The emotional involvement with parents experienced by nurses, although emotionally draining was likely a positive feature of their work. -Discussion and reflection helped to increase the understanding of emotional encounters.	-Gender not reported -Methodology unclear -Highlights the emotional stance of the nurse-patient relationship and the dual process of being emotionally drained whilst experiencing the positive features of nursing work.
Mackintosh (2006)	To explore how qualified nurses working in inpatient surgical areas cope with the daily experiences they are exposed to.	Qualitative, descriptive approach. 2 NHS Trusts (geographically close) 32 registered nurses recruited (only 16 were randomly selected to take part) due to researcher time. Semi-structured interviews based around	3 themes emerged: 1) Relationships with patients. 2) Being a person. 3) Experience. The protection of the self through the development of a work-persona. Experience was perceived as largely beneficial.	Only 16 of the 32 were interviewed therefore rich data may have been lost or saturation compromised. Limitations not acknowledged by the author

		a thematic interview schedule.		
Theodosius (2006)	Further develops the work of Hochschilds work on emotion and emotional labour and argues that an understanding of interactive nature of emotion and its unconscious processes are necessary in order that emotion and emotion management can be socially analysed,	<ul style="list-style-type: none"> -Narrative approach -Observation -Interviews -Audio diaries -n=15 	Main emotions focused upon: <ul style="list-style-type: none"> -Sharing guilt -Sharing anger 	<ul style="list-style-type: none"> -Author stated that psychoanalytic tools of transference and counter-transference were used , however the method around this was unclear. -A lot of time spent discussing Hochschilds original work leaving little room to discuss the authors empirical work. -Author acknowledges a descriptive account rather than a critical analysis.
Hunter & Smith (2007)	Consideration of the concept of emotional labour and its implications in practice.	-Guest editorial.	<ul style="list-style-type: none"> -Concept defined. -Emotional labour needed in nursing when working with distressing situations. -Deep unconscious processes at work. 	<ul style="list-style-type: none"> -Discussion / opinion piece. <i>'What is needed is an authentic acknowledgement of the significance of emotions in healthcare work...without this, it is difficult to see how the emotional wellbeing of healthcare practitioners and their clients can ever be seriously addressed.'</i> (p861).

Gray (2009)	An exploration of emotional labour in nursing and specifically defining and managing emotions in nursing work.	<ul style="list-style-type: none"> -Qualitative -East London Hospital -Registered nurses (n=6) -Student nurses (n=10) -Ethnography 	<ul style="list-style-type: none"> -Key themes: Nurse definitions of emotional labour The emotional routine of nursing. Images of nursing Barriers to emotional labour. Gender stereotypes. Professional differences. <i>'Emotional labour needs to be made more explicit and codified in order to incorporate it into policy and practice.....this gives nurses space to engage with, reflect upon and manage their own and others emotions, which greatly improves practice and the standard of patient centred care.'</i> (p173) 	<ul style="list-style-type: none"> -Ethnography cited – however methodology unclear (? Research meetings and attendance at nurse classes – participant and non-participant observation). -Link made between managing own emotions alongside caring for others. -Need for engagement within the process.
Gray & Smith (2009)	To investigate the tacit and uncoded emotions of nurses in several different clinical settings.	<ul style="list-style-type: none"> -Qualitative ethnographic study. -Based in one London hospital. -Nurses (n=16) -4 participants male -across primary care, mental health and children's oncology. 	<ul style="list-style-type: none"> -Primary care: Emotional labour is often demonstrated through the management of self and others emotions in order to be used to create comfortable environments for patients and their relatives. This often involved concealing their own emotions. -Mental Health: Unresolved emotional pressures and stresses are caused in working with mental illness and 	<ul style="list-style-type: none"> -Number of nurses in each speciality not reported. -Researchers influence in the process not clearly reported. -Findings may have limited generalisability as results are context bound to East London.

			<p>unpredictable behaviour due to duty of care and social control elements.</p> <p>-Children's Oncology: Emotional labour used to support relationships with patients, relatives and colleagues. Emotional dissonance is experienced in managing a 'good death'.</p>	
Compassion fatigue and burnout				
Boyle (2011)	Explores compassion fatigue within nursing.	-Discussion piece	<p>-Compassion fatigue is commonplace.</p> <p>-Impacts upon retention of staff, patient satisfaction and patient safety.</p>	<p>-Discussion (opinion) piece.</p> <p>-Compassion fatigue requires more deliberate attention within research.</p>
Laschinger et al (2012)	Test a model linking authentic leadership to new graduate nurses experiences of burnout and workplace bullying.	<p>-Cross sectional survey design.</p> <p>-New graduate nurses (n=342) in Canada with less than two years of experience.</p> <p>Measures: The Authentic Leadership Questionnaire. Negative Acts Questionnaire. Emotional Exhaustion Subscale of the Maslach</p>	<p>-Results supported the initial hypothesis.</p> <p>-Importance of the leader creating healthy work environments.</p>	-Cross sectional study design, precluding ability to cite cause and effect.

		Burnout Inventory – General Survey Job Satisfaction Scale Turnover Intentions Scale		
Li et al (2014)	Aimed to explore and determine whether factors such as group cohesion and organisational commitment act as protective factors for job satisfaction, compassion fatigue, compassion satisfaction and burnout.	<ul style="list-style-type: none"> -Quantitative -Children’s nurses recruited during completion of a residency programme (n=251). -231 nurses were female. -Measures (Time 1): The Life Events Checklist PTSD Checklist Civilian Version -The above measures repeated after 3 months (Time 2) alongside compassion satisfaction and fatigue test. -The above repeated after 6 months (Time 3) alongside self-report measures focusing on organisational commitment, group cohesion and job satisfaction. 	<ul style="list-style-type: none"> -Group cohesion found to be an effective protective factor in the reduction of burnout and compassion fatigue. -Organisational commitment didn’t protect against the above but it did promote job satisfaction. 	<ul style="list-style-type: none"> -Questionnaires completed in a classroom setting. -There was a need to be aware of existing stress and PTSD. -Focus on children’s nurses -Personality characteristics not focused upon.
Lee et al (2015)	To explore whether compassion can be taught in order to decrease	<ul style="list-style-type: none"> -Systematic Literature Review. -2000-2012 	-Compassion is a subjective emotion and difficult to define.	-Self-compassion is noted as a means of preventing fatigue, as is self-reflection.

	compassion fatigue and raise healthcare standards.	-13 papers appraised.	-Educators need to be creative in finding ways to evoke emotion in order to enhance compassionate care.	
Ledoux (2015)	Explores how the construct of compassion fatigue is understood in nursing.	-Discussion paper -Using literature from 1992-2012.	-No clear definition of compassion fatigue found. -Lack of clarity with the concept of compassion too. -Compassion is core to nursing.	-Compassion is core to nursing but there is a lack of clarity and understanding of the term. -To understand compassion fatigue, compassion must first be further studied. -Tools often used to measure compassion fatigue in nurses do not appear to measure compassion as a construct.
Secondary Traumatic Stress and Vicarious Traumatization				
Sabin-Farrell & Turpin (2003)	To explore the concept of vicarious traumatization (VT) and the implications for the mental health of health workers.	-Literature review	-Need to discover whether VT exists as it is currently conceptualised. -Current evidence is ambiguous and inconsistent.	-No clear methodology but results were tabled. -Research tends to focus on organisation and occupational risk factors rather than caseload. -Work to date completed with sole focus of trauma – rather

				than a mixed caseload including trauma.
Salston & Figley (2003)	The paper explores research and literature associated with secondary traumatic stress and the related variables including burnout, compassion fatigue, vicarious trauma and countertransference.	-Narrative literature review.	-Professionals are at risk of being traumatised as a result of their work. -Recognition of this is an important step in the activation of appropriate self-care.	-No literature review methodology cited. -Conflicting results in the research explored as to whether personal trauma history impacts on the risk of developing secondary traumatic stress.
Dominguez-Gomez & Rutledge (2009)	To explore the prevalence of Secondary Traumatic Stress (STS) among emergency nurses.	-Exploratory Comparative Study. -3 General community Hospitals in Southern California. -Actively employed Registered Nurses with a minimum of 6 months experience in an emergency department (n=67). -Measures: Demographic questionnaire Secondary Traumatic Stress Scale	--85% reported at least one symptom of STS in the past week. -33% met full diagnosis criteria for STS. -Need for increased awareness. -Coping strategies included: Team building, humour, reading and alternative therapies.	-The authors inserted an item on the demographic questionnaire asking nurses whether they had sought advice for work-related stress or engaged in stress management / self-care activities. -Not generalizable due to a non-random sample and one geographic location. -Self-report measures.

Beck (2011)	To review existing literature to ascertain clinical implications for nurses at risk for secondary traumatic stress.	-Literature Review: 7 studies examining STS in nurses. 2 larger samples of healthcare professionals including nurses. Variety of methodologies.	-Highest level of Compassion Fatigue found in hospital based nurses.	-Terms used interchangeably. -Suggestion for the education of nurses in developing personal strategies to prevent or ameliorate compassion fatigue. With this needing to happen alongside organisational strategies.
Nursing Education				
Maben & Macleod Clark (1998)	Presents findings from an explanatory study looking at the transition of newly qualified project 2000 nurses.	-Undertaken as an extension to a previous large scale study (n=62) had questionnaires about their perceptions of the philosophy and practice of nursing in the project 2000 context. -10 newly qualified nurses interviewed (n=5, 6 months post and n=5, 11 months post). -Analysis based on constant comparative analysis.	-Emotional highs and lows: Lows - role difficulties and problems encountered. - Stigma and negative staff attitudes. - Resistance to change. Highs - Satisfaction and fulfilment - Valued by colleagues New responsibilities and support: getting to grips with the role. - Initial skills deficit - Confidence: a contradiction - You're on your own: responsibility and accountability.	-3 month stress peak avoided as previous literature stipulated. -Author warns of generalizability difficulty due to small scale study. -Tracking of skills of newly qualified nurses through effective preceptorship in the future. -Future research looking at the impact of the practice environment.

			- Preceptorship and support: myths and realities.	
Allcock & Standen (2001)	Explore the experiences of student nurses of caring for patients in pain during the first 18 months of their training – in order to understand how these experiences may affect their sensitivity to a patients pain.	-Qualitative -Semi-structured interviews with 15 student nurses who had completed 18 months of their common foundation programme. -Thematic content analysis adapted from content analysis and classic Grounded Theory. -UK students	- 4 th theme: Students reactions of caring for patients in pain: Emotional responses to patients in pain. Being a student. Being a go-between. Coping with patients in pain. Causing pain and discomfort. -Strength of the emotional reactions felt by the student. <i>'There was little evidence in this study that students were given any help to cope with emotional labour and they were given little opportunity to discuss their feelings or try to make sense of their experiences.'</i> (p294).	-Doesn't cite where the students are from. -10 themes emerged from the data but the paper only focuses on 1 theme and subthemes. -Need to help nursing student's deal with emotional demands of the job. -A need to understand the process and concept of emotional labour.
Hunter & Deery (2005)	To explore and demonstrate value in the combination and comparison of two UK based studies which showed the evidence of emotion work in midwifery.	-Critical review of two studies: -Ethnography (n=56 student and qualified midwives) -Action research (n=8 community qualified midwives).	-Both studies demonstrated the emotional demands of working as a midwife. -Similar findings across the two studies: Impression management (managing emotions through use of acting techniques; masking	-Talks of masking and showing emotions, which contradict. -Collaboration of looking at the two studies together. -Very different samples and methods.

		-Thematic analysis used for both.	personal feelings allows the organisations business to continue unimpeded). Affective awareness (acceptable to show emotions?) Emotional overload (inadequate preparation for new ways of working).	-Allowing the organisation to continue unimpeded is interesting if staff are impacted upon – what will the long-term result of this be?
Freshwater & Stickley (2005)	Explores the concept of emotional intelligence in nurse education. Arguing for a more integrated approach to it and presenting a model of transformatory learning for nurse education.	-Discussion paper	The authors propose that nurse education should include: -Reflective learning experiences. -Supportive supervision and mentorship. -Modelling. -Opportunities for working creatively with the arts and humanities. -Focus on developing self and dialogic relationships. -Developing empathy. -Commitment to emotional competency.	-Discussion paper so opinion based. -No future research or implications noted. <i>'Emotional Intelligence needs to be placed at the core.'</i> (p96)
Coetzee & Klopper (2010)	To define compassion fatigue within nursing practice.	-Based on the framework proposed by Walker and Avant (2005). -Literature reviewed: Dictionaries (34) Books (13, with 5 relevant) Journal articles (55).	-Compassion discomfort – compassion stress – compassion fatigue (3 phases). -Impact can be calamitous for nurses. -Most frequently defined using the definitions of Secondary Traumatic Stress and Secondary Traumatic Stress Disorder.	-Literature searched from 1992-2007, due to the term being first introduced in 1992. <i>'Paints a vivid picture of the urgency of dealing with compassion fatigue in nursing.'</i> (p241)

		Theses and dissertations (9)	Therefore the literature definitions could not be used.	-Questions If recovery is possible or if the ability to be compassionate is permanently altered.
Jourdain & Chenevert (2010)	Examines the role of burnout between stress factors which relate to a nurses work / social environment and intention to leave the profession. Propose that two processes contribute to the development of burnout (Resources – Demands).	-Research model tested on nurses working in hospitals (n=1636) using a questionnaire. -92% female -Average age 41 years.	-Established links between stress factors related to burnout, which conceptualised as ' <i>a syndrome of emotional exhaustion and depersonalisation and nurses intention to leave the profession.</i> ' (p718)	-Questionnaire devised from a variety of scales focusing on demands and resources. -Authors recognised limitations as access to more sampling data. -Self-report measures. -' <i>excessive demands would be more detrimental to individuals wellbeing than insufficient resources would.</i> ' (p720)
Garrosa et al (2011)	Examines the influence of role stress and personal resources in nursing on burnout and engagement.	-Quantitative -Registered nurses from 4 general hospitals (n=508). -Measures: Nursing Burnout Scale Utrecht Work Engagement Scale The Revised Life Orientation Test	-Hierarchical multiple regression analysis used: -Significant negative association between role stress and nursing engagement. -Depersonalisation and role stress were correlated. -Personal resources had important effects.	-Limited by cross sectional design. -Self-report measures. -Important to look at personal resources when conducting burnout research.

		The Hardy Personality Scale Emotional Competence Scale	-Specifically 'hardy' personality. -Burnout is more closely related to job demands.	
Laschinger & Fida (2013)	To examine the relationship between authentic leadership and the experience of new graduate nurses on bullying in the workplace and burnout. Then to examine the above dimensions and the impact on job and career turnover intentions.	-Questionnaire Study -Graduate nurses with less than 2 years experience in Ontario, Canada (n=205). -2 Time points. -Measures: Authentic Leadership Questionnaire. Negative Acts Questionnaire – Revised. The Emotional Exhaustion and Cynicism Subscales of Maslach Burnout Inventory – General Survey. Job Turnover Intentions Scale	-Support hypothesis linking supervisors authentic leadership to work-related bullying and burnout – career and job turnover intentions. -Cynicism significantly related to experiencing bullying in the workplace.	-No data reported related to turnover, although authors do recommend this for future research.
Jack & Wibberley (2014)	To explore the meaning of relationships between pre-registered nurses and their patients focusing on the meaning of emotion work.	-IPA (Heideggerian hermeneutic phenomenology). -Unstructured interviews (n=9). -3 first year, 3 second year and 3 third year students.	-Overarching concept: Emotional Nurse Being -3 themes: -The need for emotional balance. -Feeling the need to cry. -Feeling the need to talk.	-Interviews took place in the researchers office, which may have impacted. -Multiple emotional needs of student nurses.

		<p>-Interviews lasted between 30 minutes and 1 hour.</p>	<p>-Main emotions were anxiety, grief and emotional loss of self.</p> <p>-Need for effective role models to enable emulation of emotional coping styles.</p> <p>-Student nurses need to be able to discuss their feelings and be heard.</p>	<p>-Effective support measures are required.</p> <p>-Further exploration of the positive relationships with nursing and the emotions of caring are required.</p>
Laschinger et al (2015)	Testing a model linking to authentic leadership, areas of worklife, coping self-efficacy, burnout and mental health among new graduate nurses.	<p>-Cross sectional national survey (n=1009).</p> <p>-New graduate nurses with less than 3 years experience over 10 Canadian Provinces.</p> <p>-Measures: The Authentic Leadership Questionnaire Areas of Worklife Scale Occupational Coping Self-Efficacy Scale Emotional Exhaustion and Cynicism Subscales of Maslach Burnout Inventory – General Survey. General Health Questionnaire.</p>	<p>-Results again (as with previous studies) supported the hypothesis.</p>	<p>-One year follow up data planned but not reported.</p> <p>-Authentic leaders may strengthen new nurses confidence.</p>

Appendix 3: Recruitment Poster



FOR THE ATTENTION OF ALL REGISTERED NURSES

THE EXPERIENCE OF SELF-CARE & SELF-COMPASSION IN NURSING

My name is Hannah Andrews and I am a PhD student at Warwick Medical School. I also work part time in the NHS as a Clinical Nurse Specialist and have been in nursing for 17 years.

I am inviting you as a registered nurse to take part in my research project, which will explore self-care and self-compassion in nursing. At present there is little known within this field, with research focusing on compassionate care towards our patients rather than how we as nurses care for ourselves.

The research will involve taking part in a single interview with me, which I will listen to, transcribe and analyse. This information will help me to look at common themes, ideas and the generation of theories, with the results being used to look at nursing guidelines and future training needs.

If you are interested in taking part or wish to discuss the research in more detail please contact me on the following email address:

H.Andrews@warwick.ac.uk

I will then send you further more detailed information regarding the project and arrange to meet with you.

Thank you for taking the time to read this.

Appendix 4: Participant Information Sheet and Consent Form

Hannah Andrews

REGO-2015 1614 / GF0011

Version 2: 29/07/15

Dear

RESEARCH PROJECT: The experience of self-care and self-compassion in nursing.

I am writing to invite you to take part in the above study which is being completed as part of a research degree (a PhD) at Warwick Medical School. I am also a Clinical Nurse Specialist within the NHS and have worked as a nurse for the past 17 years. I am very interested in how nurses experience self-care and self-compassion and how this may relate to compassionate care giving.

The following people are involved in this research project:

Hannah Andrews
PhD Student / Clinical Nurse Specialist
Warwick Medical School
Gibbet Hill
Coventry
CV4 7AL
07817 526507
h.andrews@warwick.ac.uk

Professor Kate Seers
Director Royal College of Nursing Research Institute
Warwick Medical School
Gibbet Hill
Coventry
CV4 7AL
02476 574041

Dr Stephanie Tierney
Compassionate Care Senior Research Fellow
Warwick Medical School
Gibbet Hill
Coventry
CV4 7AL
02476 574041

Please find enclosed a participant information sheet explaining the project in more detail and an example consent form. Please ensure you read both the participant information sheet and the consent form thoroughly before deciding whether or not you would like to take part. I am also happy to meet with you individually to discuss the project in more detail and answer any questions you may have before you make your decision.

If you decide you would like to take part or would like further information please do not hesitate to contact me via phone or email. If you do take part I will bring and complete a separate consent form with you.

I would like to thank you for taking the time to read this letter.

Yours sincerely

Hannah Andrews

Participant Information Sheet (Version 2: 29.07.15)

I would like to invite you to take part in my research project. Before you decide I would like you to understand why the research is being undertaken and what it would involve for you to take part.

Project Title

The experience of self-care and self-compassion in nursing.

What is the purpose of the project?

The purpose of the research project is to explore the following two questions:

- What are nurses experiences of self-care and self-compassion?
- How do these relate to compassionate care-giving?

Compassion and compassionate care are two key terms that are regularly heard within the healthcare setting and in more recent times have been given focus in response to difficult investigations and headline reports within the media. Compassion has been defined as a sensitivity to the suffering of the self and others, with a commitment to alleviating it (Dalai Lama, 2001). The two key themes are thus the ability to engage with and acknowledge suffering and to identify and commit to relieving it. Compassion can involve a range of feelings, thoughts and behaviours such as those aimed to nurture, look after, protect, rescue, teach, guide, mentor, sooth and offering feelings of acceptance and belonging (Gilbert, 2010). Nurses are told that compassion is important and it is embedded within policy and guidelines. The focus within existing literature is placed on compassionate care for our patients, and also what happens when nurses burnout, become fatigued or traumatised due to the type of nursing care required.

This project will shift the focus to explore whether nurses care for themselves, through self-care and how you can be compassionate towards yourself and how these experiences may relate to compassionate care giving.

Type of research being conducted

This is a qualitative research project and will involve one to one interviews. This type of research has been chosen so I can understand your own experiences of self-care and self-compassion and how you feel these experiences may relate to compassionate care giving. I plan to interview a number of nurses in order to have a diverse range of views.

Why have I been invited?

You have been invited to take part as you are a registered nurse and I am interested in understanding the experiences of registered nurses. I would value your contribution in order to gain this understanding of your experiences around self-care and self-compassion.

Do I have to take part?

You do not have to take part and are free to withdraw from the project at any time without giving reason.

What will I have to do?

If you decide to take part then I will invite you to complete a 30-60 minute interview with me, following completion of the consent form. During the interview I will meet with you in a private place away from the clinical setting. If it is easier or better for you the interview can take place in your home, at Warwick University or in a quiet room within your clinical setting. No one else but the interviewer will be present unless you would like someone else to be there. The interview will be audio recorded to enable me to focus on what you are saying rather than having to write everything down. The tape will be listened to and transcribed by me. I will remove any words from the transcript that could identify you (eg ward or staff names). These anonymized transcripts will be shared with my two supervisors (Professor Kate Seers and Dr Stephanie Tierney), but no-one else outside of this. All identifying information will be removed in all publications and presentations of the research.

Duration

The time commitment for the project will be a single interview. I may then contact you via email or telephone to check the accuracy of the interview data once it has been transcribed. This is to ensure you are happy with what has been completed and are also given the option to have any of the information removed if you so wish.

Risks

I will be asking you to share your personal experiences and ideas around self-care, self-compassion and compassionate care giving. Should you feel uncomfortable talking through these topics you do not have to answer the questions, or continue to take part should you not wish to. You do not have to give me a reason for not responding to any question or for withdrawing from the interview.

If psychological distress, negative consequences or anxiety generated as a consequence of participating in this research, then I will signpost you to appropriate support.

If any practice is observed or disclosed which is deemed dangerous (i.e. relating to illegal activity, risk behaviours or professional misconduct) then this must be acknowledged and dealt with in accordance with local policy and procedure. I will encourage you to report and discuss any concerns or issues with your manager if you have not done so already.

Benefits

Whilst some people find talking about experiences can be helpful, this research is not designed to benefit you directly. This research will help to inform the evidence base regarding self-care, self-compassion and compassionate care giving within the field of nursing. The aim will be to benefit the nursing workforce within this area and add to the currently very limited existing pool of research evidence.

Who to contact

If you have any questions you can ask them at any point using the contact details on the front sheet.

Who should I contact if I want to make a complaint?

Please be assured that any complaint you may have regarding the way you have been treated during the study, or any distress or harm that has occurred will be addressed. Please refer any complaint to the person below, who is independent of this study:

Director of Delivery Assurance
Registrars Office, University House
University of Warwick
Coventry
CV4 8UW
complaints@Warwick.ac.uk
02476 574774

This research proposal has been reviewed and approved by University of Warwick's Biomedical and Scientific Research Ethics Committee (BSREC) and also with the NHS Research and Development departments for University Hospitals Coventry and Warwickshire NHS Trust and Coventry and Warwickshire Partnership Trust.

Consent Form

The original consent form once signed will be kept in a secure place by the researcher Hannah Andrews and you will be provided with a copy for your own records.

Project Title: The experience of self-care and self-compassion in nursing.

☐

Principal Investigator: Hannah Andrews

Participant Declaration: I the participant:
Please initial the boxes

☐

Have read the information sheet and understand the contents.

Have been given an opportunity to ask questions and am
satisfied with the answers.

☐

Consent to take part in the research project.

☐

Understand that participation is voluntary and that I can withdraw
at any time.

☐

Consent to possible publication and presentation of the findings
which may include anonymized quotations.

☐

Researcher Declaration: I the researcher:
Please initial the boxes

☐

Have explained the research study to the participant.

Have answered questions put to me by the participant about the
research.

Believe that the participant understands and is freely giving consent.



Participant Statement:

I have read this information sheet and consent form. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research project. I understand I may withdraw from the study at any time. I have received a copy of this consent form.

Participant Name:

Participant Signature:

Contact Number:

Email Address:

Date:

Researcher Statement:

I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

Researcher Name:

Researcher Signature:

Date

Appendix 5: Interview Guide

INTERVIEW SCHEDULE (Version 1: May 2015)

Project Title: The experience of self-care and self-compassion in nursing.

The interview will take the form of a conversation. Interviewees will have the opportunity to raise issues of importance to them. This topic guide may therefore change as data collection progresses.

Background Questions:

-Male / Female

-What year did you qualify?

-What is your current post / job title?
(If appropriate discuss clinical experience)

-Could you describe the clinical setting you currently work in?

Questions relating to Self-Care:

-What do you understand by the term self-care?
(towards patients / towards self)

-What happens regarding self-care within your work place?
(Prompt for examples)

-Are there any barriers to self-care?

-at work?

-at home?

-Is there anything that facilitates self-care?

Questions relating to Self-Compassion:

- What do you understand by the term self-compassion?
- How far do you feel that you are compassionate towards yourself?
(Experiences of self-compassion. The things people have written about in the literature are: Kindness, recognising fallibility, self-soothing, acceptance, commit to relieving suffering, mindful of present state, humanity)
- What are your thoughts regarding the role of self-compassion?
 - Impact on work life?
 - Impact on home life?
- What are the barriers to self-compassion?
- What facilitates self-compassion?
- Are you able to care for yourself during times of stress?
(Prompt for examples. What about other times?)
- Has there ever been a time when you have found nursing to have an impact on your health?

Questions relating to Compassionate Care:

- What do you understand by the term compassionate care more generally?
- What are your thoughts regarding providing compassion to your patients?

-How is compassionate care viewed within your work place?

-How do you think compassionate care is viewed within nursing at present?

-Are there things / factors that you think help you provide compassionate care?
(Others have said there might be a link between self-compassion and compassionate care. Do you think this or not really?)

Other questions:

-Is there something else you would like to say?

Final Considerations:

-Thank them for taking part and state how much their participation / views / experiences are appreciated.

-Do you have any questions you would like to ask about the interview?
(Any thoughts / comments)

When the research is finished would you like to see a summary of the results?

What would you like your name to be when I type the recording? (Or do you want me to assign you a fictional name? Advise they will also be assigned a number)

Additional topics added to follow lines of inquiry:

- Motivations for going into nursing
- Nursing Identity
- Impact of leadership
- Professional persona
- Compassion received from others
- Impact of caring – who recognises this
- Whose responsibility is it? (self-care & self-compassion)
- Permission

Appendix 6: Examples of initial codes & initial coding process

Initial Codes (Gerunds)

Changing Roles	Supporting Colleagues
Being part of a process	Motivating self
Feeling stressed	Being a burden
Defining roles	Moving & Switching mind-sets
Feeling pushed	Sitting in the minds of others
Impacting negatively on health	Struggling NHS
Resisting change	Caring for colleagues
Experiencing bullying	Making excuses / Justifying actions
Using experience to move forward	Attending to basic needs
Pressuring self	Needing to self-care
Being hard on self	Having no concept of self-care
Focusing attention on others	Making time for others
Feeling tired	Relating to others
Burning out	Communicating and Acting
Accepting what life has given you	Acting and Resolving
Wanting to be good	Feeling insulted
Improving	Finding a balance
Doing the best we can	Changing NHS vs Changing Nurses
Needing role models	Needing a support network
Feeling useful	Gaining from work
Having a purpose	Needing to offload / vent
Feeling powerful / feeling in control	Allowing space
Building Resilience	Taking things home
Building Tolerance	Lacking self-compassion
Acknowledging Humanity	Needing to be heard
Recognising experience	Getting on with things
Finding the time	Feeling blocked
Pushing self	Feeling threatened
Feeling lucky	Helping each other
Being stuck	Feeling able
Feeling trapped	Moving on
Getting close to burnout	Overwhelming feelings
'Dragging me through'	Holding difficult incidents in mind
Coming out the other side	Using own experiences
Losing nurses	Laughing about it
Instigating action	Being represented
Getting self in a state	'Gaining their respect'
Overwhelming responsibility (painful)	Giving all of yourself to another
Working hard	Questioning the problem
Raising morale	Putting self at risk
Overtaking self-care	Knowing own limitations
Formalising needs	Making time for self
Getting back to family	Needing to learn
Needing positive public perception	'Getting on with it'
Being brave	Having to act
Fearing what others will say	Setting targets
Remembering significant events	Facing consequences
Feeling overlooked	Improving recruitment
Feeling upset	Feeling depressed
Being told what to do	Having a say
Attending to needs	Knowing something is wrong
Telling somebody	Changing culture
Having the courage	Changing times

Standing up for ourselves	Needing to be seen to be busy
Being task orientated	Prioritising needs
Bringing past methods back	Feeling shocked
Dealing with the consequences	Being observed helping
Blurring roles	Protecting self
Behaving in a certain way	Separating home and work
Taking a professional attitude	Not limiting self-care at home
Working through it	Engaging with self

Interview with RGN11	
RGN11: I think my mentor when I first qualified, you know my management placement, she was very much like 'make sure you have a home life balance, you're no good if you're purely here', they say leave your home things at the door but that's not always possible (no), and it's not realistic to expect that and I think we're, we're restricted because of sickness policies, because of other policies that have come about and it's, if anything we're more at risk of becoming unwell because we're exposed all the time yet we're scrutinised for it, maybe a little bit, erm so my manager always said 'they will always get the service running, you make sure you look after yourself', (right ok), and I think I've never really adhered to that but the last twelve months I probably have more so (mmm).	
Initial Coding: Line by Line	
she was very much like 'make sure you have a home life balance, you're no good if you're purely here', they say leave your home things at the door but that's not always possible (no), and it's not realistic to expect that	Being protected by the manager Work-Life balance Being no good if no balance exists Keeping work and home separate Not being possible Unrealistic expectations
I think we're, we're restricted because of sickness policies, because of other policies that have come about and it's, if anything we're more at risk of becoming unwell	Being restricted by policies Being more at risk of becoming unwell Policy increasing risks Changing policies
because we're exposed all the time yet we're scrutinised for it, maybe a little bit, erm so my manager always said 'they will always get the service running, you make sure you look after yourself', (right ok), and I think I've never really adhered to that but the last twelve months I probably have more so (mmm).	Feeling exposed Being scrutinised Us and them Looking after yourself Not adhering to guidance Changing adherence

Interview with RMN8
RMN8: I see it as part of my identity definitely erm I feel like working where I work now I feel there's lots of role erosion erm and for a long time I was the only nurse in my team and the only full time member of staff (wow ok) so I was erm and sometimes we have people like us to try and be professions that we're not and I'm quite passionate about being proud of being a nurse and flying the flag for it (yeah) erm I really love that, that's who I am and that's my profession and I never want to lose it, erm I'm really, you know I love that so it is, I think I definitely fall in the category of it's part of who I am, my identity.
Initial Coding: Line by Line

I see it as part of my identity definitely erm I feel like working where I work now I feel there's lots of role erosion	Being part of the identity Feeling a sense of role erosion
for a long time I was the only nurse in my team and the only full time member of staff (wow ok) so I was erm and sometimes we have people like us to try and be professions that we're not	Being the only nurse in the team Working full time Differing professions
I'm quite passionate about being proud of being a nurse and flying the flag for it (yeah) erm I really love that, that's who I am and that's my profession and I never want to lose it, erm I'm really, you know I love that so it is, I think I definitely fall in the category of it's part of who I am, my identity.	Being passionate Feeling proud 'Flying the flag' Loving the identity Not wanting to lose it Being a nurse Nursing identity

Appendix 7: Example of focused codes, categories and data*

Initial Codes	Focused Codes & Categories	Examples of Participant Data (Taken from NVIVO)
<ul style="list-style-type: none"> -Being part of the process -Defining roles -Blurring roles -Needing role models -Having a purpose -Having no concept of self-care -Being stuck -Feeling trapped -Feeling frustrated -Pressuring self -Being hard on self -Engaging with self -Working through it -Coming out the other side -Not limiting self-care at home -Making time for self -Needing to learn 	<ul style="list-style-type: none"> -Having no concept / Difficult concept -Role modelling as a precursor -Being unable to engage (Recognition not leading to action) -Being blocked -Needing to recognise and engage with the self -Learning process 	<p>Internals\Participant 19 references coded, 4.16% coverage Reference 1: 0.18% coverage when I first started as a nurse it was that, I didn't even think about self care as a concept Reference 2: 0.51% coverage but there is nothing in the training programme about making me aware of self care, there was nothing, erm and I think that when you, you know you look at the physical aspect of the job of which is quite significant, the emotional impact of our job is significant Internals\Participant 1 1 reference coded, 0.53% coverage Reference 1: 0.53% coverage if your sister or the lead nurse or your matron or you know, and if they treat you without respect how are you, you know you're learning that, you know you're, that's your role model, that's your boss, if you like so its so, it's got so many things that are interlinked with it, Internals\Participant 16 2 references coded, 0.83% coverage Reference 2: 0.66% coverage I always found myself 'oh I wanted to be like you', you know and it was lovely and I always remembered her erm but I also remember those that 'oh god there's no way', 'no way I want to be like you'. I could think of a couple like that, you think god, you know they ruled by fear (mmm) and stuff and that's, you get nothing out of nobody for that (yeah). They'd put the fear of god, you'd hear those keys jangling on the belt and you'd think 'oh my god look busy', you know. Internals\Participant 21 1 reference coded, 0.50% coverage Reference 1: 0.50% coverage I know that I've got a lot of friends that have had very different styles of parents and I think you can see that in the way they are and the things they struggle with. Internals\Participant 27 2 references coded, 0.79% coverage Reference 1: 0.26% coverage I suppose role modelling really, looking at people that are good at it that demonstrate compassion erm I think I've probably been quite keen on that. Reference 2: 0.53% coverage I think role models are really key and having leaders in your teams that are role models, that can show it to other people is quite important erm there's no point me saying oh you know</p>

		<p>you've got to be compassionate but I'm not going to be coz that isn't going to work so it's about showing it yourself and leading.</p> <p>Internals\\Participant 302 references coded, 1.28% coverage</p> <p>Reference 1: 0.65% coverage</p> <p>I certainly can still think about people that have influenced my clinical life, they were stood out as role models. I thought I want to be like that person, because they were amazing (mmm) and those energised words and those behaviours are sadly lacking now, they're lacking.</p> <p>Reference 2: 0.62% coverage</p> <p>always be kind, don't try and be negative and disrespectful, always try and see through an issue, always look for a positive thing and that's what's kept me going. I think it came right from childhood, it didn't just suddenly spring onto me when I came into nursing.</p> <p>Internals\\Participant 61 reference coded, 2.23% coverage</p> <p>Reference 1: 2.23% coverage</p> <p>I think there is a link to, yeah yeah and I think that probably goes back to you know, how you, how you were brought up, what was expected of you, you know your life, what you were allowed, you know how well you were at self-caring and being allowed self-care as a child, and growing up you know and I used to think 'oh I hate all this it goes back to my childhood', but it does, I think and your ability but it's something you can learn (yes), you know it's something that we can learn and I think, I really think that when you work in a profession like this, it's something that should be taught on the curriculum, it should be you know 'you will need, you know at some point in your career, there will be times when you will really need to address your self-care', yeah, yeah.</p>
<ul style="list-style-type: none"> -Toxic nurses -Needing to feel valued -Feeling insulted -Character of the nurse -Strength of character -'not professionally trained to be a person' -separating professional role from personal role -protective casing around professional role 	<ul style="list-style-type: none"> -Nursing character -Nursing Identity -Professional Identity and role -Hardwired to be caregivers -Professional role / identity 	<p>Internals\\Participant 1 reference coded, 0.95% coverage</p> <p>Reference 1: 0.95% coverage</p> <p>I know that not everybody can be a nurse, you know, it has you know, its not an easy job (no), but I think, that those of us who are capable of providing you know very good care, I think that erm, I don't know I just think, that if I'm not aware of it, I'm one of many, do you know what I mean (yeah) and I just think that the impact of not being aware you know of, of you know as a concept you know at the forefront of your mind then you're not as likely to think you know ok so what am I going to do about this?</p> <p>Internals\\Participant 191 reference coded, 2.85% coverage</p> <p>Reference 1: 2.85% coverage</p>

<ul style="list-style-type: none"> -Social beings -Being wonder woman -Wanting to be good /improving -Taking a professional attitude -Nurse bred into person -Demeanour should be one of compassion -Knowing own limitations -Protecting self -NMC code to adhere to -Grief / loss of previous identity -Sense of unfairness -Being dealt this -Helplessness -Feeling pushed -Resisting change -‘Nobody’s going to listen’ -Verbalising your pain 	<ul style="list-style-type: none"> -Changing roles -Possessing and presenting certain characteristics -Core values -Fear of change -Feeling punished 	<p>I think there’s always been nurses who are I suppose what you might call ultra carers that they kind of go way beyond their normal hours or the normal kind of remit that you would expect which is fine in itself but they’re doing it almost constantly so it seems, erm but it does also feel as though that pressure has grown more and more erm and there’s, you know there’s so many different factors that have created that but it does feel that, that pressure is growing erm and the movement towards erm sort of constant measurement of what we’re doing (ok) also I think creates that pressure as well (mmm), not that, that’s not important, it is important but it’s sort of, so for example when we go to complete our initial assessment there’s a proportion of it that seems to be about providing information for the corporate body rather than actually we’re here for patient care to gather information about the patient (right ok), so there’s all that additional pressure. It’s not to say we shouldn’t be doing that but they are additional pressures erm that I see kind of weighing on everybody really and certainly in the fellow () teams they’re under so much pressure (mmm) and I think, well it’s quite wide isn’t it that pressure.</p> <p>Internals\\Participant 221 reference coded, 0.29% coverage Reference 1: 0.29% coverage</p> <p>Well I think that there is that whole wanting to help people that I think is generally in most nurses</p> <p>Internals\\Participant 271 reference coded, 0.42% coverage Reference 1: 0.42% coverage</p> <p>I think I’m a nurse through and through, I think it’s in my blood, I think it’s in my spirit, I think it’s in everything I do erm but it’s even if it’s not around mental health, I’ll still want to talk about everything around health and about how to care</p> <p>Internals\\Participant 32 references coded, 0.62% coverage Reference 1: 0.31% coverage</p> <p>think its, its bred in to some nurses, you know you see something happening and you’ve got to deal with it.</p> <p>Reference 2: 0.32% coverage</p> <p>its ingrained into what she is, she’s not young, she’s in her fifties and so its been ingrained for a long time</p> <p>Internals\\Participant 41 reference coded, 0.18% coverage Reference 1: 0.18% coverage</p> <p>some personalities want to take everything on that’s just the way they are, they will get over involved erm and not stand about.</p>
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<ul style="list-style-type: none"> -Looking out for junior staff -Improving recruitment -Togetherness -Using own experiences -Concern for new nurses -Losing nurses -preventing stress -feeling alone -Experiencing bullying -Positive interactions -Compassion can be taught -Supportive colleagues -Unsupportive colleagues -Being kind -Sitting in the mind of others -Caring for colleagues -Needing a support network -Sense of togetherness -Concern for new nurses -‘Dragging me through’ -Being included -Feeling isolated -Raising morale -Helping each other -Having to act -Knowing something is wrong -Attending to -Standing up for ourselves -Telling somebody -Having a say -Having the courage -Complaint leading to action -Sense of purpose 	<ul style="list-style-type: none"> -Supporting others / Being supported / Lacking -Giving and receiving compassion -Needing stability / Control -Getting through it together -Speaking out -Being in control 	<p>Internals\\Participant 183 references coded, 1.72% coverage Reference 1: 0.78% coverage If we don’t do that how can you expect our staff to do that for our patients (mmm), we have to you know everybody’s a person at the end of the day, everybody has vulnerabilities, everybody has their challenges erm and their moments of distress and we have to, doesn’t matter if it’s a member of staff or a patient you know distress is the same erm vulnerability is the same erm we have to provide that compassion erm to people. Reference 2: 0.45% coverage it’s about how can we look after you when you’re at work because I’m sure when they come back a lot of this will be to do with erm stress and overwork and being overwhelmed with stuff and that impacting then on you know bad backs and things like that. Reference 3: 0.50% coverage If we don’t look after each other and have compassion for each other and have things aimed at compassion, so we can understand compassion and how it applies to our self-care and care of each other, how can we possibly do that with our, with our most vulnerable patients.</p> <p>Internals\\Participant 191 reference coded, 1.16% coverage Reference 1: 1.16% coverage Fortunately we have good supervision channels in our team so there’s the opportunity to talk about that and we manage our caseloads quite closely (mmm) so that we don’t become over stressed (right) and if that does happen then we try and pick up work from each other (yes) but I feel we do have clear communication with our management and I see that as not so present in other areas but fortunately we’re quite good at that. I think that’s because we are a small team so we’re able to do that more readily.</p> <p>Internals\\Participant 204 references coded, 3.23% coverage Reference 1: 0.65% coverage I tend to say if you need me and they’re co-ordinating just call me at home (right) even late at night or at the weekends because I’d rather they feel safe erm and then I can help them or put them in the right direction so it is quite difficult (laughs). Reference 2: 0.24% coverage if I know someone’s not had a break I’ll make sure they go and even if that means I don’t get one Reference 3: 0.72% coverage I just have this guilt, this overwhelming guilt and I’m just like ‘oh no they need to’ whereas I know I can keep going, which is quite naughty really, on a serious note it is quite bad erm but like I say it’s always something that I’ve always had in my head, it’s like OCD I think.</p> <p>Internals\\Participant 286 references coded, 2.01% coverage</p>
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<p>-Taking too much on</p> <p>-'No time to care'</p> <p>-'The job is never done'</p> <p>-Being task orientated</p>	<p>-Finding a balance</p> <p>-Being too busy</p>	<p>Internals\Participant 112 references coded, 1.24% coverage</p> <p>Reference 1: 0.55% coverage</p>

<ul style="list-style-type: none"> -Sense of urgency -Work frenzy -Working hard -Overtaking self-care -Getting back to family -Taking things home -Home life suffering due to work life -Building pressure (feeling constant) -Rushing around -Just doing -Separating home and work -Unable to return -Personal Journey -Pushing self -Getting on with things 	<ul style="list-style-type: none"> -Making time for self -Being part of a journey 	<p>I think it's a good work life balance. I think it's erm initiatives at work that make sure you've got, I think the trust values and people respecting each other, it's erm managing appropriate work loads (ok).</p> <p>Reference 2: 0.69% coverage</p> <p>'make sure you have a home life balance, you're no good if you're purely here', they say leave your home things at the door but that's not always possible (no), and it's not realistic to expect that and I think we're, we're restricted because of sickness policies,</p> <p>Internals\Participant 122 references coded, 1.38% coverage</p> <p>Reference 1: 0.35% coverage</p> <p>o there can be a powerful pull between work life and home life, you know so the expectation that 'oh well you'll stay on and deal with a crisis', erm can create incredible sort of problems for people.</p> <p>Reference 2: 1.03% coverage</p> <p>but it is a hard skill to learn to kind of erm boundary oneself, keep oneself, the core of oneself as separate from patient experience (mmm), and I think people respond to that in different ways and more or less impact, so some people manage to achieve a good balance and then some people you see put a hard shell around themselves and quite dismissive of people, and then some people you know find themselves too permeable and get overwhelmed by people's experiences (ok), erm so learning to sort of manage that and not be too hard on yourself when things go wrong for our patients.</p> <p>Internals\Participant 162 references coded, 1.00% coverage</p> <p>Reference 1: 0.19% coverage</p> <p>Yeah coz workload doesn't go away does it, it's just how you manage that (absolutely) and manage self so that it's healthy balance.</p> <p>Reference 2: 0.81% coverage</p> <p>if I do for some reason leave at five I feel guilty coz it's only five (right), which is ridiculous and I know it is but actually that's just I guess the, what you let happen to yourself without realising it and that's not self-care, and I know it's not self-care coz you shouldn't be able to, if you're coming in at eight, eight thirty and working through till five that's more than acceptable but actually get yourself into this spiral of thinking and I've actually said it, feel like I'm wagging it (laughs) coz I'm leaving at five and that's ridiculous isn't it?</p>
<ul style="list-style-type: none"> -Fearing what others will say -Link to media characters 	<ul style="list-style-type: none"> -Public perceptions of nursing (versus self perceptions) -Being viewed in a particular way 	<p>Internals\Participant 15 references coded, 1.57% coverage</p> <p>Reference 1: 0.13% coverage</p> <p>its very easy to go low so if you're treated with respect and dignity</p> <p>Reference 2: 0.10% coverage</p>

<ul style="list-style-type: none"> -Public expecting compassion -Being observed helping -Being allowed to nurse -Behaving in a certain way -Needing to be seen to be busy -Needing positive public perception -Pressure feeling constant -Gaining their respect -Being part of policy -Others as a barrier 	<ul style="list-style-type: none"> -Needing positive regard 	<p>it is stressful at times and we're not feeling valued</p> <p>Reference 3: 0.27% coverage</p> <p>when you don't feel valued I think that possibly you can't look after yourself as well as you could potentially and its easy to get in a rut,</p> <p>Reference 4: 0.43% coverage</p> <p>if you're in a culture, workplace culture that you know you don't feel valued, where you work, you don't feel valued from the government, you don't feel valued from the public, because of all the trouble that we've had.</p> <p>Reference 5: 0.64% coverage</p> <p>I think the press could do with some really good stories as well, rather than the negatives, because we have got some excellent nurses and we have got excellent care. Erm I think we should be celebrated more (mmm) erm you know for what we do do, but on top of that support nursesto be able to do better (yes), do you know what I mean?</p> <p>Internals\\Participant 141 reference coded, 0.76% coverage</p> <p>Reference 1: 0.76% coverage</p> <p>sometimes recognition from other people helps, I think you know people work their arses off and it feels unrecognised a lot of the time, not in the team but I think higher up, you know and those little personal touches to things like you can send a generic email out to everybody in the trust and say well done and you're all doing really well but actually everyone's like 'well do you know what we do, do you know who I am?'</p> <p>Internals\\Participant 162 references coded, 0.72% coverage</p> <p>Reference 1: 0.38% coverage</p> <p>I think there's also something about visibility of people like myself and senior managers being able to be visible and reassure them that actually 'we're fighting your corner' (mmm), we know this doesn't feel right, there's a lot of service redesign going on,</p> <p>Reference 2: 0.34% coverage</p> <p>Yeah I think and it's part of what we try to do in our department, our directorate is take somewhat of a bottom up approach and actually you're the people on the ground, you're the clinical experts, you tell us how you think this might work.</p>
<ul style="list-style-type: none"> -Past affecting present -Historical issues as a block -Sense of looking back -Bringing past methods back 	<ul style="list-style-type: none"> -History shaping self-care -Changing / Struggling NHS 	<p>Internals\\Participant 12 references coded, 0.95% coverage</p> <p>Reference 1: 0.69% coverage</p> <p>it's a bit frustrating with the NHS, been going for over 60 years, been frustrating because everything's been kind of medicalised and we've kind of been not mollycoddling but you</p>

<ul style="list-style-type: none"> -The bigger picture -Moving on -Using experience to move forward -Sense of uncertainty -Change working its way down -Changing culture -Changing times -Organisation not facilitating compassion 	<p>(Changing NHS versus changing nurses)</p> <p>-Needing to be in the present</p>	<p>know we've taken on, you know the medical team, the medical system, nurses, doctors have taken over, a kind of paternalistic, kind you know I'll have this medication',</p> <p>Reference 2: 0.27% coverage</p> <p>you know obviously with the debt that the NHS is in and you know that we're struggling. That, that's a worry, (yeah), you know as a nurse.</p> <p>Internals\\Participant 102 references coded, 1.27% coverage</p> <p>Reference 1: 0.69% coverage</p> <p>but I think that is something that's missing within our erm nursing today (right ok), yeah I think there's lots of issues going on, and they're not being addressed (right), so erm you know this conflict resolution actually isn't happening, (mmm) and I think that's one little piece of why people may be feel disgruntled and miserable (ok), and not happy.</p> <p>Reference 2: 0.58% coverage</p> <p>I think what nursing is lacking is damn good leadership (mmm). Now I can only talk from mainly working within an acute hospital trust. I think that erm, and so I think erm self-care, I do feel in some ways looking back on it all, I actually think there was more self-care when I was training than there is now</p> <p>Internals\\Participant 111 reference coded, 0.67% coverage</p> <p>Reference 1: 0.67% coverage</p> <p>Definitely, I think clinical, I think our scope of practice has changed erm I think things like our specialist nurses and our advanced nurse practitioners are taking more of a forefront erm but I feel like the basic bits of nursing are being left behind.</p>
<ul style="list-style-type: none"> -Burning out -Feeling overlooked -Feeling upset -Needing to go off sick -Feeling depressed -Feeling shocked -Questioning ability -Overwhelming feelings -‘who looks after us’ -Mental wellbeing -Physical ill health -Impacting negatively on health -Physical wellbeing 	<p>-Impact of caring</p> <p>-Burning out</p> <p>-Blocking compassion</p> <p>-Being well</p> <p>-Needing to be cared for</p>	<p>Internals\\Participant 111 reference coded, 0.46% coverage</p> <p>Reference 1: 0.46% coverage</p> <p>I think again it's probably me taking more reflection and thinking 'ok you're at a bit of a brink now tell somebody', rather than just carry on, carry on, carry on, and not stop.</p> <p>Internals\\Participant 122 references coded, 1.12% coverage</p> <p>Reference 1: 0.37% coverage</p> <p>Yeah but I mean overall it's not a good thing to burnout of your career and it's not something I'm going to recommend anybody to do (mmm) and coz there are lessons that I learnt that I you know, that I'm careful now.</p> <p>Reference 2: 0.75% coverage</p> <p>first of all I think you have to be aware that it happens and it can happen to anybody because certainly in my twenties I was quite sort of rising star, I built my career quite well erm and I thought, I never thought it could happen to me and in fact when it, when I saw it happen to</p>

<ul style="list-style-type: none"> -Feeling fatigued -Feeling stressed -The cost of acknowledging -Dealing with the consequences -Tough compassion -Being a burden -Getting close to burnout -Limiting self -Self-nurturing -Needing to self-care -Being medicalised -Getting self in a state -Not giving attention to -Formalising needs -Extremity of feelings -Engaging with others -Becoming the norm -Nurses need to be doing -Nurses need to be caring -Making time for others -No quick fix -Gaining from work 	<ul style="list-style-type: none"> -Refusing to engage -Formal process required -Managing emotions -Gaining from caring -Attending to basic needs 	<p>other people I was kind of slightly dismissive (mmm). I was kind of like that that was a personal thing to them that must be linked to their personality Internals\Participant 141 reference coded, 0.43% coverage Reference 1: 0.43% coverage it was all a culmination of things really and my anxiety just started to go through the roof erm and I was trying to just still carry on and be there and do it and it just got to a point where, I mean I had a bit of a erm just burst into tears at work Internals\Participant 151 reference coded, 0.64% coverage Reference 1: 0.64% coverage I think you do sort of like build a wall up so the abuse you get just tends to go over your head a lot of the time (ok), erm coz I think if you didn't have that wall I don't think you'd cope a week (mmm), because I think you'd get too much pressure within yourself really (ok). If you took everything to heart I don't think you'd cope very long (mmm). Internals\Participant 162 references coded, 1.12% coverage Reference 1: 0.44% coverage I'd spend a lot of it crying (right), thinking I'm crap, I shouldn't be in this job, I'm no good at it, I haven't done this, you know I feel like I'm not giving quality and it got to the point where it was beginning to take over if you like (mmm), you know I'd get butterflies walking in thinking what haven't I done, Reference 2: 0.67% coverage Yeah, you always fall off the edge and I've seen that happen to people and I was actually mindful of that coz I have had a previous manager who's just amazing who fell off the edge but you see what that does for people around you is makes them feel guilty because 'what didn't I see, what could I have done', and I didn't want that for people that I work with erm but I was very mindful actually not falling off the edge but not quite sure what to do (yes) to make that not happen. Internals\Participant 172 references coded, 1.45% coverage Reference 1: 0.91% coverage there isn't that self-compassion there at all because you feel you're the one that should be there, that should be doing the do and what have you, erm I suppose it's there in the background but it takes a while for you to realise that's what you need to do for your own self-preservation (yeah) and that's why you get a lot of burnout, coz people haven't come to the understanding that they need to be compassionate for themselves. Reference 2: 0.55% coverage</p>
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		<p>you almost get to that burnout point where you think I can't do this anymore and then think 'well why am I doing what I'm doing' (yeah), it's a bit like a light bulb moment, 'Aaagh I think I need to do something about this, start looking after myself for a change'.</p>
<ul style="list-style-type: none"> -Accepting what life has given you -Doing the best we can -Feeling useful -Instigating action -Feeling able -Feeling powerful & in control -Building resilience -Building tolerance -Acknowledging Humanity -Recognising experience -Finding the time -Motivating self -Empowering self -Moving & Switching mindsets -Needing realistic solutions -Making excuses -Justifying actions -Prioritising needs -Setting targets -Communicating & Acting -Acting & Resolving -Needing to offload -Allowing space -Lacking psychological focus -Knowing own limitations -Making time for self -Questioning the problem -Laughing about it 	<ul style="list-style-type: none"> -Coping behaviours -The self as a tool for change -‘Turning a page’ -Taking responsibility -Accepting a cycle of compassion 	<p>Internals\Participant 274 references coded, 2.16% coverage Reference 1: 0.21% coverage at the moment I feel like I manage it ok erm because I have that thick skin and it's what I do erm but I think there may be a time Reference 2: 0.80% coverage I don't think it's conscious I think it is repeated exposure, I think you know oh god here's another thing happened and ok well I'll deal with that next time coz it won't shock me next time and we're unshockable almost aren't we, especially in mental health. We hear and see things that lay people wouldn't erm and I wouldn't want people to see everyday erm and actually when you sit and think and talk about some of the things that we deal with, actually it's horrific Reference 3: 0.44% coverage It would give people nightmares erm but it doesn't so I think it becomes, it builds over time erm I think probably at eighteen walking into a mental health unit I was a lot more scared, there was probably a lot more effected by those things but yeah it builds up. Reference 4: 0.72% coverage 'I've watched every single one of you when we were reading through that report and not one of you flinched, not one of you looked horrified at what you'd just heard' and actually it was quite shocking and he was right none of us did, so yes I think those barriers come up and you protect yourself and you use mechanisms to protect yourself but I don't think they are conscious, I think they just happen and evolve over time Internals\Participant 102 references coded, 0.62% coverage Reference 1: 0.26% coverage I still feel that even though it was distressing at the time I was able to do you know eventually erm move on (mmm), and not hold on to it. Reference 2: 0.36% coverage you know but I can dust myself down (mmm) and start all over again, and I've never felt that something has happened that I've hung on to and never moved on from (mmm), that is truly how I feel. Internals\Participant 141 reference coded, 0.93% coverage Reference 1: 0.93% coverage</p>

		<p>Yeah I can still remember it as clear as day, there is a lot of stuff that I still remember that I don't really, it's one of those you don't, until you remember it and talk about it and think 'god that actually happened, didn't it, we actually did that', we had to go through that and deal with that situation, and I think of some of the stuff I've done over the years and I think 'my god' (laughs), 'how did I do that', 'how did I manage that', it's mad, it's mad that it doesn't have more of an impact if that makes sense.</p> <p>Internals\Participant 151 reference coded, 0.52% coverage</p> <p>Reference 1: 0.52% coverage</p> <p>Massively, massively, every time I think it's done and dealt with it comes back, yet for some reason that's the only incident that ever does. I think it's the worst incident I've ever been in for the eleven years I've been there, that's probably the worst one I've been in.</p> <p>Internals\Participant 224 references coded, 4.86% coverage</p> <p>Reference 1: 1.98% coverage</p> <p>I don't know whether it's true across like all nursing culture but I feel like there's that well we get on with it, we hold things especially I think in () coz nursing is traditionally held high risk in () so you've got all these things going on and real horrible things erm you know real significant self harm and traumas that children go through and you're just like 'ok right what's happened now, oh someone's been raped, oh what's happened now oh there's a suicide and you're like ok next thing lets go see' and sometimes we just get a bit hardened to that (mmm) and then when it catches all up on you and you think oh no this is awful, this has happened in one day, it's not very nice.</p> <p>Reference 2: 1.40% coverage</p> <p>I saw some things and I just thought that's ridiculous and I think that it's kind of a bit like exposure really when you keep on day in day out having all that happen you do get a bit hardened to it and it is really difficult erm and you know you do have to balance that out a little bit really and make sure that you're not to, I think it can go the wrong way erm it's good to be mindful of it really, you don't want to start being cold but you do just get used to it I think, I think over time erm yes.</p> <p>Reference 3: 0.48% coverage</p> <p>I just try not to hold it even though I'm accountable I definitely want to run it past 'can you believe this has just happened' and then just leave it like that then.</p> <p>Reference 4: 1.00% coverage</p> <p>I think that it probably depends, I'd probably be a bit like 'oh I'll just brush it off, anyway lets move on' (laughs), I think that there's something you know that I'd do a bit of that but when erm when you're really going through it I think it's welcomed. I think when you're really having a tough time I think it's very welcomed in my eyes anyway.</p>
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<ul style="list-style-type: none"> -Providing care -Focusing attention on others -Enabling the patient -Putting personal life on hold -Giving all of yourself to another -Ethos of the organisation -Expense of themselves -Not putting self first -Busy looking after others -Putting self at risk 	<ul style="list-style-type: none"> -Prioritising patients (Putting the patients first) -Sacrificing the self -Offering too much -Doing what the organisation wants -Needing a sense of self 	<p>Internals\\Participant 141 reference coded, 0.43% coverage Reference 1: 0.43% coverage I think I'm in a very privileged position really to be able to say that. I don't get up and dread going to work or anything like that, even when I've been struggling emotionally at work I've never got up and dreaded the thought of going in.</p> <p>Internals\\Participant 151 reference coded, 0.28% coverage Reference 1: 0.28% coverage It's always them and you, you're there to do a job, you have to deal with that, you're not there to, you've gotta cope with whatever's thrown at you</p> <p>Internals\\Participant 211 reference coded, 1.19% coverage Reference 1: 1.19% coverage one thing I learned from being here which I hadn't really, I hadn't really worked in this way before was that it's not about you trying to solve their problems for them it's trying to help them to solve their problems and I guess that's what we get told a lot here is that you're trying to help them become more independent rather than fixing everything for them which you kind of do on the ward,</p> <p>Internals\\Participant 31 reference coded, 0.31% coverage Reference 1: 0.31% coverage she was giving compassionate care, putting her own needs to the back and the ward manager was allowing that</p> <p>Internals\\Participant 51 reference coded, 0.38% coverage Reference 1: 0.38% coverage Well self-care within our workplace to be honest is about the patient (ok), when they said self-care it's all the patient.</p> <p>Internals\\Participant 61 reference coded, 1.66% coverage Reference 1: 1.66% coverage It sometimes takes you aback and you think 'well, thanks', and, but it's really nice, I think it's really nice to have them say, you know to actually recognise that, that you care and that they care for you, yeah, yes. I've spoken to various colleagues over the years and I think one of the things, that's quite evident in all sort of the nurses that I know is that, the majority of people, we're very very good at giving, but not very good at receiving (mmm), yeah, yeah we get very good at giving, giving time, giving care, giving but we're not very good at receiving (ok).</p> <p>Internals\\Participant 71 reference coded, 2.14% coverage Reference 1: 2.14% coverage I think there probably is because if you feel good in yourself I'm sure that you'll give better care, well I know that you do, you see it, I see it in myself if you feel better within yourself</p>
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		<p>you're much more buoyant so your interaction with the patient is better erm and I think yeah you do give better care if you're feeling in a good place yourself (yeah), yeah definitely, you see it in others if they're very stressed it's you know it's hard isn't it, to interact with other people, so I think yeah, I think it is important.</p>
<ul style="list-style-type: none"> -Needing good leadership -Top layered -Trust responsibility -Being told what to do -Raising awareness -Patient's to understand -Relating to others -Others as powerful -Feeling trapped -Shifting power & position -Ability for autonomy (as facilitator) -Taking time out (as enabler) -Allowing time -Allowing self to be ill -Needing to be heard -Giving self permission -Self-care being seen as a weakness -No time to care -You as a barrier -'They're in our world' 	<ul style="list-style-type: none"> -Needing effective leadership -Having formal permission to self-care -Having sufficient tools -Giving yourself permission (? key category) -Barriers to caring -Nurses World (Control & Power) -Patient as vulnerable 	<p>Internals\Participant 1 3 references coded, 1.03% coverage Reference 1: 0.70% coverage my understanding of self care for me just as a nurse without any of my other hats on (laughs) as we said, erm is you know, making sure that you know, you must have enough sleep to be able to do your job, these are basic things, I think, that when you get down to it, you know you need to make sure you have enough sleep, of course with babies and things that can be tricky Reference 2: 0.10% coverage we need to be able to look after ourselves better, Reference 3: 0.23% coverage you know what we're nurses we know, what we need to do with our lifestyle. Whether we choose to or not is another matter. Internals\Participant 12 1 reference coded, 0.94% coverage Reference 1: 0.94% coverage You see the trend in management is to say 'ahh it's the responsibility of everybody, everybody's responsibility ,we're all in it together' (laughs), and yes there are individual responsibilities erm I don't doubt that and clearly individuals respond differently and you can see that in working life and some people will fall at the end of the parameter when they're really not taking basic steps to take care of themselves for sure, but I do think that leaders need to have some kind of focus on staff, where staff welfare sits, Internals\Participant 13 3 references coded, 2.93% coverage Reference 1: 1.67% coverage I know what it involves and I know I'm able to but I don't necessarily think that I prioritise it, but it's not a priority (mmm), erm obviously it's a demanding job isn't it (yeah), erm you've got your home life it's quite busy you know. I'm married with children and I don't necessarily think I prioritise my time to look after myself as well you know. Reference 2: 0.53% coverage I think it's just like you said, lots of other pressures you know, not intentional it just falls by the wayside. Reference 3: 0.73% coverage I get a sense that it's more the individual's responsibility to seek out that support in order for them to maintain their own wellbeing and self-care.</p>

		<p>Internals\Participant 162 references coded, 0.31% coverage Reference 1: 0.23% coverage I am trying to work with my self and have a word with myself that actually 'switch off, you've got to switch off so you're fresh the next day when you come back', Reference 2: 0.09% coverage I guess just, just telling myself that it's ok to switch off</p>
<ul style="list-style-type: none"> -Protective factors -Sense of guilt -Overwhelming responsibility (Painful) -Loss -Mindlessly doing -Being brave -Lacking self-compassion -Feeling blocked -Feeling sad -Feeling threatened -Not feeling ready 	<ul style="list-style-type: none"> -Acknowledging and allowing emotions (flow of compassion) -Being hard on self -Recognising own limitations 	<p>Internals\Participant 151 reference coded, 0.46% coverage Reference 1: 0.46% coverage I don't know if I did then, if I'm honest I felt like I went to complete pot erm and I think I was, it's hard to remind myself of what I needed to be coz I was telling myself I should be snapping out of it, it's part of the job, I've just got to deal with it Internals\Participant 232 references coded, 2.66% coverage Reference 1: 0.90% coverage There's almost a sense of 'oh she's great, she copes brilliantly with everything, she's got that many balls up in the air and she can still manage it all' and it's almost seen to be erm a positive thing to be like that erm whereas to be seen not to be like that is quite often you know people erm look at it in a negative way, it's a weakness (ok). Reference 2: 1.76% coverage It's very, very difficult for a young nurse to say that erm and they want to be seen to be doing the right thing and they don't want to be seen to be difficult erm so there's definitely that pressure, so there's a personal pressure to yourself, there's a team pressure about not letting your colleagues down and then very much again an organisational pressure I think because you know those senior to you and those above them and those above them they're constantly erm you know targets to reach and things that need to be achieved and then that filters down to the next line and the next line and the next line so erm I think it comes in three directions, yeah very much. Internals\Participant 243 references coded, 5.36% coverage Reference 1: 2.12% coverage I've actually said to colleagues you know you need to, you're getting quite stressed and then obviously they think it's a failure on their part so then they don't, not that I don't think they listen I think they say 'yeah, yeah, yeah' and obviously it comes to burnout and they're off sick, so then obviously it effects the department. I think it's recognising when people, coz I think other people are embarrassed to admit that they are struggling and they can do everything and not share things out (yeah). Reference 2: 1.06% coverage</p>

		<p>I think it's fear, it might be fear of getting told off or like somebody saying you're not doing a good job or do you know what I mean, trying to impress and then it affects their health (ok) and then they go off sick (yeah) and it's picking up the extra work so.</p> <p>Reference 3: 2.19% coverage</p> <p>other colleagues quite hard on themselves and they take it very personally and you know they get quite upset about it (ok) and I think they find it hard to talk to people about it because they feel they let people down, a failure, especially when I qualified, coz when you qualify you're quite eager to sort of impress and all that so you, back then I would be like sort of worried about things you know doing the right thing and like you say we all make mistakes then when you qualify as well you just don't want to make any mistakes.</p> <p>Internals\Participant 41 reference coded, 0.47% coverage</p> <p>Reference 1: 0.47% coverage</p> <p>ometimes you feel good about being self compassionate, if that is being self-compassionate, when you're feeling sorry for yourself erm theres an element of guilt because actually you're better off than lots of people and often the things that I might worry about, other people would give their hind teeth to have that you know</p> <p>Internals\Participant 63 references coded, 5.63% coverage</p> <p>Reference 1: 0.29% coverage</p> <p>As a failing, I think it's viewed as a weakness (ok), yeah I think it's viewed as a weakness. (pause)</p>
<ul style="list-style-type: none"> -Feeling sorry for yourself -Overwhelming feelings -Holding difficult incidents in mind 	<ul style="list-style-type: none"> -Self-compassion as too overwhelming -Being viewed as a weakness 	<p>Internals\Participant 162 references coded, 1.05% coverage</p> <p>Reference 1: 0.44% coverage</p> <p>I'd spend a lot of it crying (right), thinking I'm crap, I shouldn't be in this job, I'm no good at it, I haven't done this, you know I feel like I'm not giving quality and it got to the point where it was beginning to take over if you like (mmm), you know I'd get butterflies walking in thinking what haven't I done,</p> <p>Reference 2: 0.61% coverage</p> <p>there'll never be enough hours in the day I know that, but it just got to the point where I wasn't caring for myself erm because of work load, because of priorities, because of anxieties about others (mmm), not feeling supported maybe (ok), then actually I just got to the point where I'm thinking 'I'm not doing a good job at this', it never crossed my mind to not do it, or to look for something else coz I absolutely love it,</p> <p>Internals\Participant 23 references coded, 2.92% coverage</p> <p>Reference 1: 1.39% coverage</p>

	-Giving all of yourself	<p>but you're seeing it in people who have been recently qualified (right ok). I find that a little worrying, you know they're getting quite stressed out and I think we're going to lose nurses a lot younger, you know they're gonna come through, they're gonna qualify and if we don't support them we're going to lose them at quite a young age and let's be honest nursing can't afford to lose any more nurses (no absolutely). So we do need to start helping them to care for themselves.</p> <p>Reference 2: 0.55% coverage</p> <p>I can see nurses coming through their training now who are you know recently qualified going on to the wards and seeing people who are just so overwhelmed with everything that are going on.</p> <p>Reference 3: 0.97% coverage</p> <p>I do love the job as a ward sister, I still maintain that, that is one of the hardest jobs. I think it's harder than the job I do now erm and I think it's probably one of the hardest jobs within the NHS really, is the sisters role and I don't think that that's necessarily recognised, erm about the amount of pressure that we put on them (mmm).</p> <p>Internals\\Participant 221 reference coded, 1.98% coverage</p> <p>Reference 1: 1.98% coverage</p> <p>I don't know whether it's true across like all nursing culture but I feel like there's that well we get on with it, we hold things especially I think in () coz nursing is traditionally held high risk in () so you've got all these things going on and real horrible things erm you know real significant self harm and traumas that children go through and you're just like 'ok right what's happened now, oh someone's been raped, oh what's happened now oh there's a suicide and you're like ok next thing let's go see' and sometimes we just get a bit hardened to that (mmm) and then when it catches all up on you and you think oh no this is awful, this has happened in one day, it's not very nice.</p> <p>Internals\\Participant 231 reference coded, 1.16% coverage</p> <p>Reference 1: 1.16% coverage</p> <p>There's always a pressure on nurses I think. There's a sense of you know get on with it, you know your colleagues, you know if you're not in your colleagues have to pick it up or you know 'what's wrong with you toughen up, you're not coping very well with it' erm and there's a real sense of that and that is still out there I think to some degree erm a pressure to appear to be coping erm and everything's fine erm and sometimes it plainly isn't.</p> <p>Internals\\Participant 281 reference coded, 0.11% coverage</p> <p>Reference 1: 0.11% coverage</p> <p>because you always feel responsible, I think it must be horrendous working on the wards for that</p>
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		Internals\Participant 3 1 reference coded, 0.58% coverage Reference 1: 0.58% coverage because you're giving all of yourself to someone else aren't you? so I mean there are some nice easy jobs here but I think that the majority of them have some stress related element to them.
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*** Core categories are described in appendix 8**

Appendix 8: Theoretical Coding

Focused Codes	Major Categories	Theoretical Codes / Concepts	Core Theoretical Concepts	
<ul style="list-style-type: none"> -Having no concept / Difficult concept -Role modelling as a precursor -Being unable to engage (Recognition not leading to action) -Being blocked -Needing to recognise and engage with the self -Learning process 	<ul style="list-style-type: none"> -Training and experience -Background and early experience -Needing role models 	<p><u>Motivating Factors</u></p> <ul style="list-style-type: none"> -The nursing story and background appears important – what motivated them to nurse and how does this relate to the nursing identity. -A focus on background, early experience and early role models appears key. 	<p>‘Hardwired to be caregivers’</p> <p>Becoming and being a nurse</p> <p>(Are nurse’s hardwired to be caregivers? What is it about their story / journey that makes this so. Nurse as self – versus nurse as professional role. These can appear separate and more blurred depending on numerous internal and external factors. This appears related to the ability to give or receive permission in order to care for the self).</p>	<p>CORE CONCEPT*</p> <p>Needing Permission to self-care and be self-compassionate</p> <p>-Giving self-permission (Taking ownership, ‘failing rather than a need’, understanding and offering self-compassion, Acknowledging and permitting humanity, recognising experience)</p> <p>-Receiving permission (Making and having time, organisation and culture, Having permission at home and work)</p>
<ul style="list-style-type: none"> -Nursing character -Nursing Identity -Professional Identity and role -Hardwired to be caregivers -Professional role / identity -Changing roles -Possessing and presenting certain characteristics -Fear of change -Feeling punished -Needing a sense of self 	<ul style="list-style-type: none"> -Nurse as self -Nurse as a role -Nursing Character -Possessing compassion 	<p><u>Nursing Identity</u></p> <ul style="list-style-type: none"> -Knowing self identity, and the factors involved in this awareness. -Possessing a particular nursing character with core values. -Is compassion innate or can it be learnt and nurtured as part of the nursing identity. -Identity as a fluid process. Nurse as self and nurse as role, with these appearing blurred at times and may change related to commitment to the organisation, how the nurse 	<p>Giving self-permission (The ability to do this appears directly related to the factors involved with nursing identity and the motivations to nurse, including early messages, leading to accessibility and acceptability).</p>	

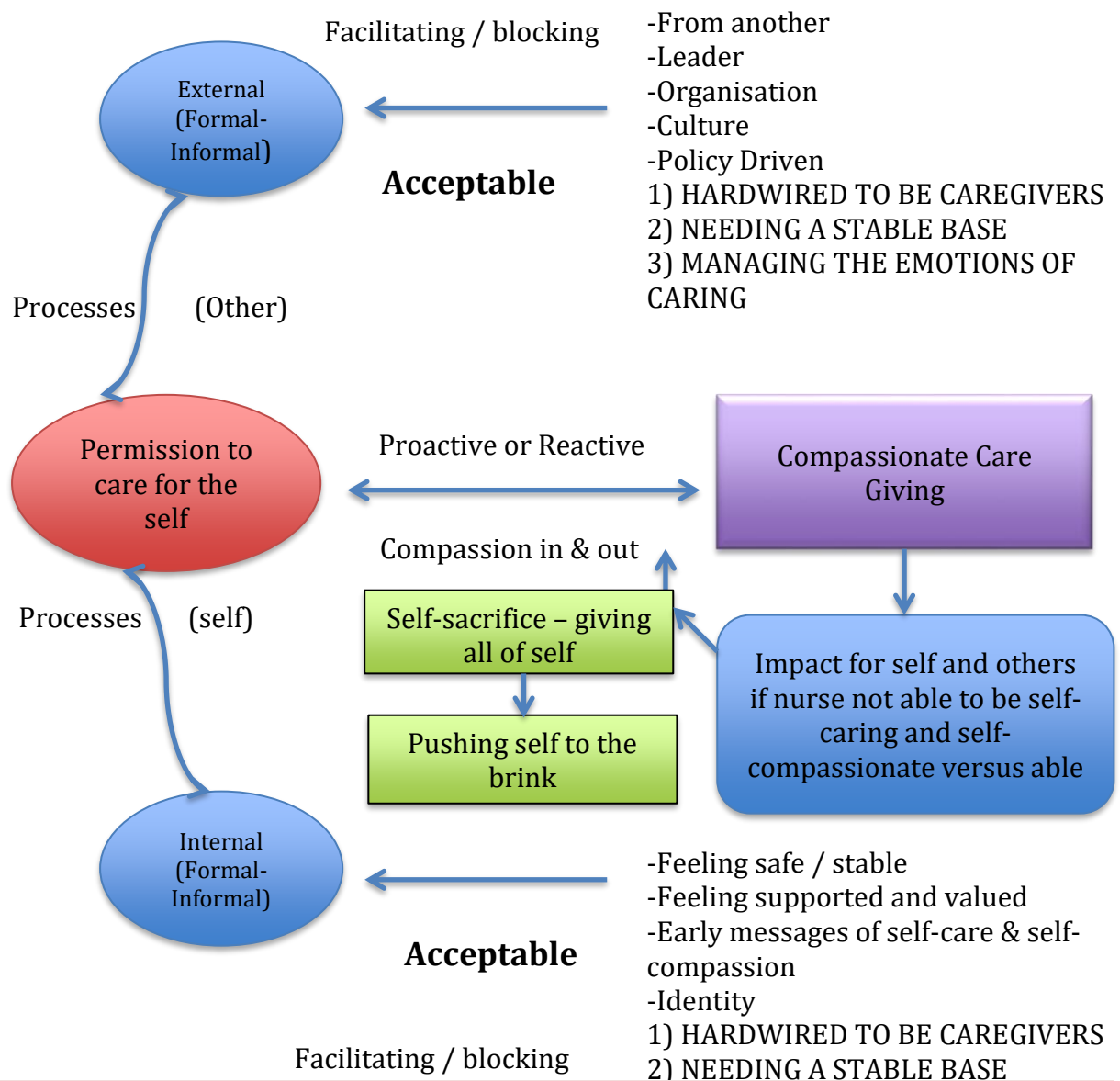
		has been treated and whether they feel valued.		<p align="center">CORE CONCEPT*</p> <p>Needing Permission to self-care and be self-compassionate</p> <p>-Giving self-permission (Taking ownership, 'failing rather than a need', understanding and offering self-compassion, Acknowledging and permitting humanity, recognising experience)</p> <p>-Receiving permission (Making and having time, organisation and culture, Having permission at home and work)</p>
<ul style="list-style-type: none"> -Supporting others / Being supported / Lacking -Giving and receiving compassion -Needing stability / Control -Getting through it together -Speaking out -Being in control -Needing effective leadership -Having formal permission to self-care -Having sufficient tools -Giving yourself permission (? key category) -Formal process required -Barriers to caring -Nurses World (Control & Power) -Patient as vulnerable 	<ul style="list-style-type: none"> -Being supported and valued -Caring for each other -Effective Leadership -Permission from self and others -Process driven 	<p><u>Feeling Safe</u></p> <ul style="list-style-type: none"> -Being able to trust others in a supportive environment. -Being responsible for others and caring for each other. -Having a good and effective leader – this appears key in creating a feeling of safety and stability. <p><u>Formal and informal permission</u></p> <ul style="list-style-type: none"> -The need for permission is tied into process, for many seek formal permission in policy and guidance. However, there is also a need for individual ownership alongside organisation / cultural. 	<ul style="list-style-type: none"> -Needing permission (Nurses appear to need permission in order that self-care and self-compassion is deemed and viewed as acceptable). Needing a stable base (There appears a need for a stable base in order to care for the self and others. When there is instability and uncertainty and a feeling of being unsafe and 'at risk', the ability to permit the self or receive permission to care for the self is more tenuous. A number of barriers and facilitators, external and internal affect this). -Receiving permission (If permission is not received then self-care and self-compassion can be viewed as a 'weakness', with nurses feeling guilty) 	
<ul style="list-style-type: none"> -Public perceptions of nursing (versus self perceptions) -Being viewed in a particular way -Needing positive regard -Needing to feel valued -Trying to escape -Wavering loyalty -History shaping self-care -Changing / Struggling NHS (Changing NHS versus changing nurses) 	<ul style="list-style-type: none"> -Sitting in the minds of others -Changing NHS 	<p><u>Living with uncertainty</u></p> <ul style="list-style-type: none"> -The NHS is viewed as changing and 'broken' by many, so it is understandable that this may impact. -There is a sense of looking back in order to cope with the current situation, but this can lead to frustration as to how things once were. It is unclear from the data if nurses were able to care for themselves in 		

-Needing to be in the present		the past when things were considered more stable.	if they apply it – this relates to patients first).	<p>CORE CONCEPT*</p> <p>Needing Permission to self-care and be self-compassionate</p> <p>-Giving self-permission (Taking ownership, ‘failing rather than a need’, understanding and offering self-compassion, Acknowledging and permitting humanity, recognising experience)</p> <p>-Receiving permission (Making and having time, organisation and culture, Having permission at home and work)</p>
-Gaining from caring -Prioritising patients (Putting the patients first) -Sacrificing the self -Offering too much -Doing what the organisation wants	-Gaining from caring -Putting the patient first -Feeling lost if unable to care	<u>-Needing to care</u> -The idea that nurses go into nursing to care for others and there is a sense of loss if they are unable to do this. -The wish is to enable the patient, focus on others, relate to others and make the patient the priority.	Managing the emotions of caring (There appears a need to proactively manage the emotions of caring, rather than reactively if nurses are to prevent burnout and compassion fatigue. Nurses tend to push themselves to the limit and sacrifice themselves in order to care for their patients).	
-Coping behaviours -The self as a tool for change -‘Turning a page’ -Taking responsibility -Acknowledging and allowing emotions (flow of compassion) -Being hard on self -Recognising own limitations -Finding a balance -Being too busy -Making time for self -Being part of a journey -Building a wall	-Using compassion -Showing compassion -‘Turning a page’ -Closing off -Building resistance and tolerance	<u>-Learning to cope and manage</u> -Nurses appear to want to use and show compassion to others, but they often need to learn to cope and manage the emotions of this. -There is a tendency to close off, build a wall and block difficult emotions rather than processing them. This has long term implications and consequences.	Being permitted to care for the self whilst caring for the patients (There is a need to recognise a cycle of compassion, so both compassion in and out, and to recognise that it is acceptable to care for the self alongside caring for others. There is a need to allow emotions, empower the self and engage with the self. This process needs to be permitted by the self and others / culture).	
-Impact of caring -Burning out -Blocking compassion -Self-compassion as too overwhelming -Being viewed as a weakness -Being well -Needing to be cared for -Refusing to engage -Managing emotions	-Feeling stressed -Offering too much -Burning out -Refusing to engage -Accepting a cycle of compassion	<u>-Struggling to recognise the need to cope and manage</u> -There is a sense of being unable to cope or recognise the need to, which leads to a cycle of pushing themselves and thus burnout out ‘pushing to the brink’.		

-Attending to basic needs		-Nurses become overwhelmed, and hold too much in mind, and struggle to manage this.		
Social Processes			Core Social Process	
<p>-Needing to feel safe and secure within the self and with others. Secure and trusting relationships with others</p> <p>-How the general public and society perceive nurses in general. Impact of negative health enquiry</p> <p>-Business led model of care and the processes encompasses within this</p> <p>-Deep seated social perception of nursing as an intrinsic part of an individuals being, which is tied to caring for others</p> <p>-Perceiving the whole being as a nurse with little or no sense of self outside of this (both internal and external processes)</p> <p>-The need to legitimise the need for self-care</p> <p>-Why is it viewed as acceptable to sacrifice the self in order to care for others (internal and external)</p> <p>-Viewing what needs to happen (caring for the self) but not being able to engage in the process due to perception of others.</p> <p>-How nurses relate to the NHS – Commitment to the organisation / ‘Us and Them’</p>			<p>The need for Permission – feeling permitted to care for the self</p>	

***Core concept repeated on each page for ease of reading.**

Appendix 9: Theory Development



Self-care and self-compassion need to be fully understood and engaged in proactively rather than reactively, with an awareness of the internal and external factors, which may block or permit this.

There is a sense that self-care and self-compassion need to be embedded within nursing education and the overall nursing culture. This would then serve as a form of permission and also mean that the concepts are more accessible and acceptable.

Making the link between compassion in towards the self and out towards the patients would protect nurses from pushing themselves to the brink, self-sacrificing and help them to manage the emotions of nursing more effectively.

Appendix 10: Example of a Research Memo

Memo

'I want to perform well'

11th September 2015

Participant 1 stated at the start of the interview that she wanted to perform well, give me what I need for my research:

'I want to be able to give you what you need, this is important research'

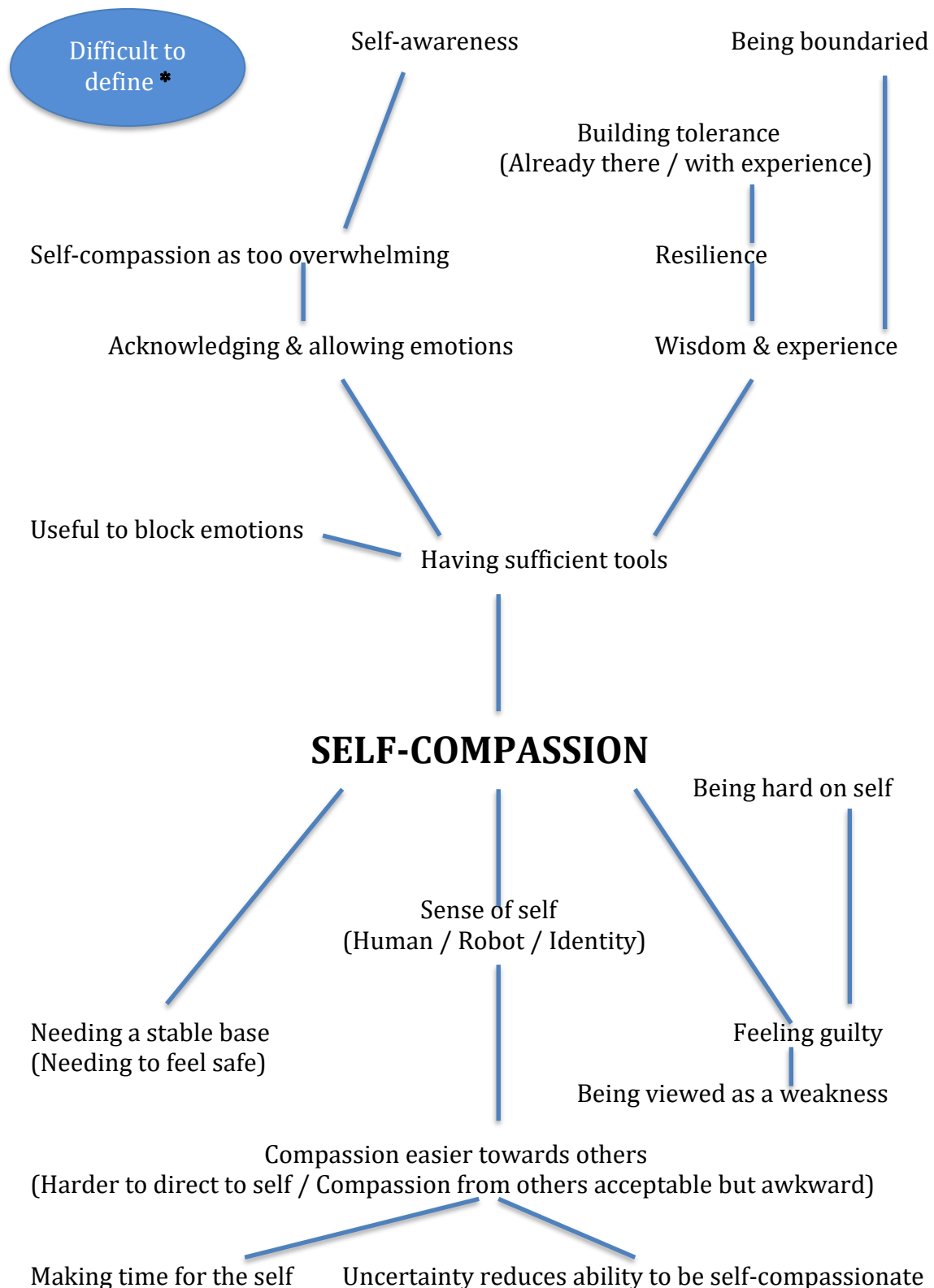
Participant 2 also stated:

'I hope I can give you what you need'

They seemed to immediately place pressure on themselves to perform. Where does this pressure come from? Internal Vs External. This made me think about what the research is trying to achieve, finding out the perceptions and viewpoints of others without intended pressure. However that pressure certainly for this person exists, why? Does it come back to the character of the nurse, or is it more about individual traits? Or is it more simplistic than this, that it is their first experience of participating in research and they want to 'do well', and that they view this topic as important.

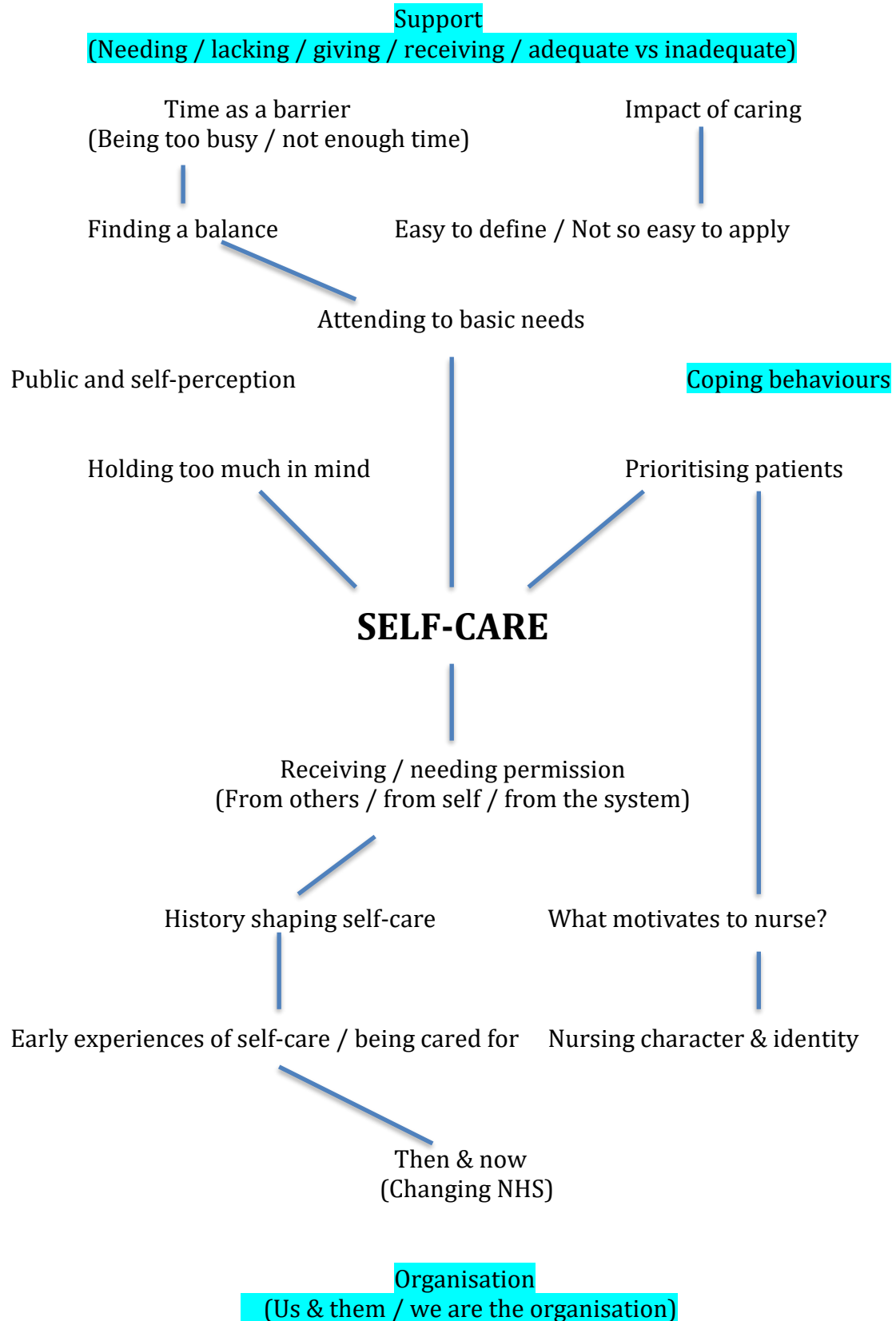
How much do we as nurses place pressure on ourselves and how much is it external and how might this then get in the way of self-care, self-compassion and compassionate care.

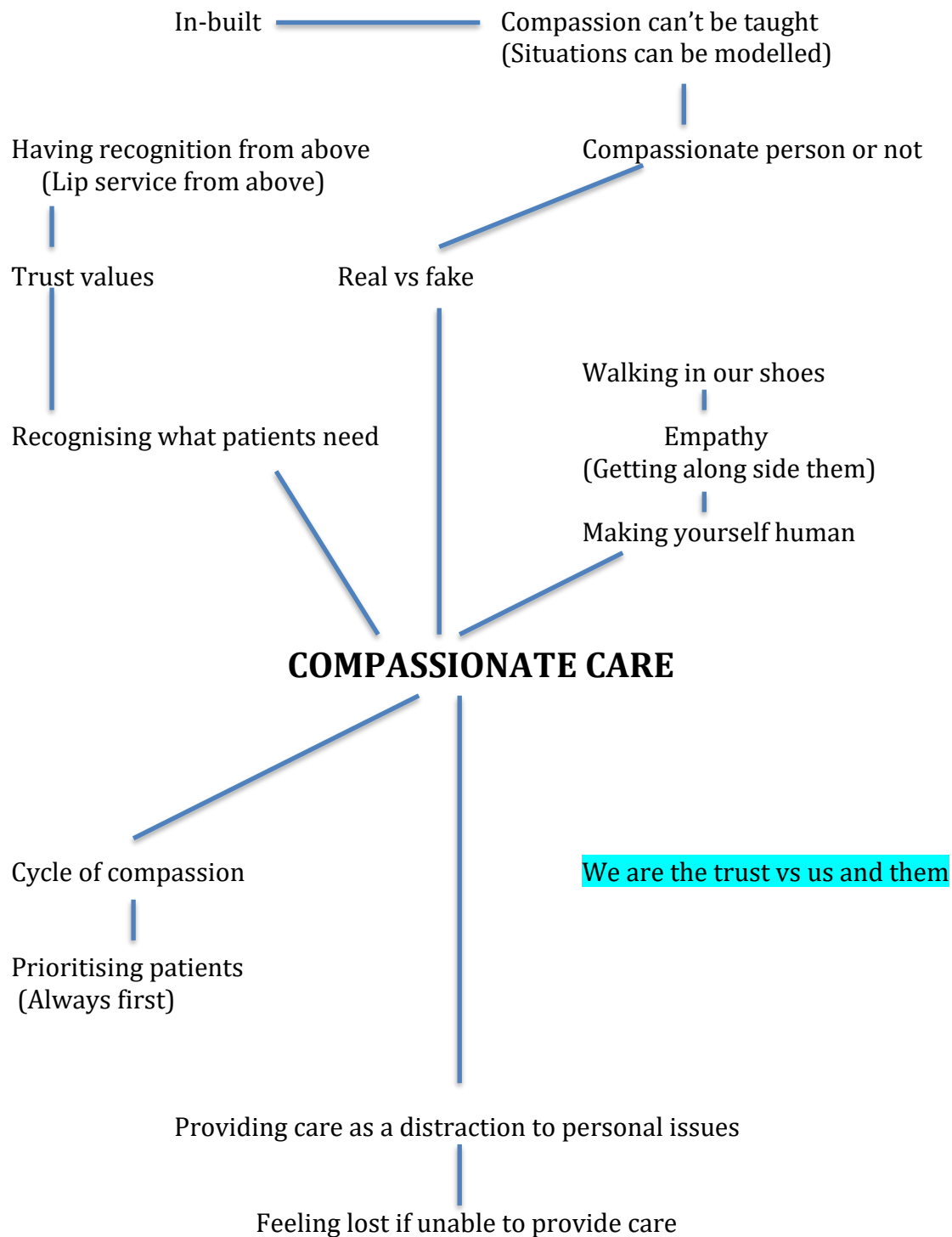
Appendix 11: Mind map / clustering - Initial codes of the concepts as described by the participants



Facilitating - Having recognition from above

* Concept defined in the literature but difficult for the participants to define or access





Appendix 12: Example of a Reflexive Journal Entry

Pushing Self to the Brink

‘We’re always asked to look after patients, who looks after us?’ (P2)

Nurses are first and foremost caregivers, caring for their patients, saving them and helping them, however what happens when nurses push themselves to the brink in order to provide that care. Is this at the expense of their own wellbeing? Who looks after the nurses? Why is it that some nurse’s struggle and others don’t? In my experience as a nurse I have never reached burnout, however there have been times when self-care and self-compassion have been easier for me than others. For example when I worked shifts and having a changeable routine, this proved a slight barrier to eating well and I would often go long periods of time without eating. It was only when I started to experience stomach problems (IBS) that I realised maybe my poor diet is contributing. Was this my way of getting to the brink with my physical health before realising the need for intervention?

The journey to becoming a nurse is different for everyone, the motivating factors that trigger the thought of wanting to do nursing is a very personal experience. Whether it is a need to care, to make a difference or a decision to take on that role as ‘just a job’ can motivate people towards a career in nursing. Other variables include the character of the person, compassion, identity and core values, with some people identifying that they are just ‘hardwired to be caregivers’. People often begin their training with clear ideas around the type of nurse they may want to be and early role models in the field can then help shape these ideas and embed clear early messages.

Once qualified as a nurse a “safe and stable base appears to be important with a need to feel safe and to fit in within the team with which you work. Being able to trust those around you and feel as if you are in a supportive environment helps the nurse to cope with an ever changing NHS and the uncertainty this can often bring. Many nurses reflect on the need to have a good, effective leader in order to feel safe at work and with it a sense of feeling valued.

When times are difficult at home or at work there appears a need to be self-caring and to recognise and attend to needs but nurses appear to need permission in order to do this. This might take the form of taking ownership for their own wellbeing, asking for help and finding a balance if they are to avoid a negative impact on their health. In order to help this process there needs to be a level of self-awareness and motivation in recognising what needs to be done and of course a realistic approach and acknowledgement that management of time will be a factor.

Self-compassion appears harder to define than self-care and compassionate care giving, and is seen as a ‘failing rather than a need’. Nurses appear to find self-compassion difficult with a tendency to be hard on self rather than applying kindness. Nurses are often unable to prioritise or empower self in order to engage with their own self and suffering. There is a need to acknowledge their humanity,

allowing emotion and recognising that nurses are not machines but rather human beings with their own experiences and limitations. There is a need to build resilience and tolerance however it is unclear how and if these are built sufficiently enough to deal with the day to day challenges of being a nurse.

When looking at care of the patient this is easier to define, patients come first and a nurse's job is to show compassion, provide care and enable the patient. However nurses are able to recognise 'the job is never done' and sometimes it feels that too much is being held in mind. Nurses also reflect that by focusing so much on others, they themselves are forgotten and there is a tendency to feel lost if unable to care. Their identity becomes one of a nurse often at the expense of their own sense of self.

The longer term impact of this is feeling stressed due to pushing self and feeling as if there is an overwhelming responsibility due to taking too much on. Nurses worry about how they sit in the minds of others and how they are perceived. There is a fear of caring too much and what this means, with this seemingly applying to both care of the patient and care of the self. Many nurses talk of storing difficult experiences with one relating it to a book 'turning the page' as each incident occurs. The book is never closed but the pages keep being turned and revisited when similar incidences occur.

Appendix 13: Letters of access and Ethical Approval

30th July 2015

Warwick
Medical School

PRIVATE
Mrs Hannah Andrews
PhD student
Health Sciences
Warwick Medical School
University of Warwick
Coventry
CV4 7AL

Dear Mrs Andrews,

Study Title and BSREC Reference: *The Experience of Self-Care and Self-Compassion in Nursing* REGO-2015-1614

Thank you for submitting your revisions to the above-named project to the University of Warwick's Biomedical and Scientific Research Ethics Sub-Committee for approval.

I am pleased to confirm that approval is granted and your study may commence.

Please keep a copy of the signed version of this letter with your study documentation.

Yours sincerely



Professor Scott Weich
Chair
Biomedical and Scientific
Research Ethics Sub-Committee

**Biomedical and Scientific
Research Ethics Sub-Committee**
A010 Medical School Building
Warwick Medical School,
Coventry, CV4 7AL
Tel: 02476-528207
Email: BSREC@Warwick.ac.uk

Medical School Building
The University of Warwick
Coventry CV4 7AL United Kingdom
Tel: +44 (0)24 7657 4880
Fax: +44 (0)24 7652 8375

THE UNIVERSITY OF
WARWICK

Research Passport Application Form – Version 3 01/09/2012

Please refer to the guidance notes before completing the form.

Section 1 - Details of Researcher - To be completed by Researcher			
1.	Surname: ANDREWS	Prof Dr Mr Mrs Miss Ms Other	
	Forename(s): Hannah		
	Home Address: [REDACTED]		
	Work Tel: h.andrews@warwick.ac.uk	Mobile: [REDACTED]	Email:
2.	Date of birth: 01/01/80	Gender: Male Female	
	Ethnicity: White British	National Insurance number: [REDACTED]	
3.	Professional registration details, if applicable (Doctors undertaking any form of medical practice should confirm they have a licence to practise). Clinical Nurse Specialist NMC registered / pin number: 00143300		
4.	Employer: Coventry & Warwickshire Partnership Trust or place of study: Warwick University		
	Work Address/Place of Study: Warwick University Warwick Medical School Gibbet Hill Coventry CV4 7AL		
	Post or status held: PhD Student / Clinical Nurse Specialist		
Section 2 - Details of Research - To be completed by Researcher			
5.	What type of Research Passport do you need? Project-specific <input type="checkbox"/> Multi-project <input type="checkbox"/>		
	<i>If you will be conducting one project only please complete the details below. If you anticipate that you will be undertaking more than one project at any one time, please give details in the Appendix.</i>		
	Project Title: The Experience of Self-Care and Self-Compassion in Nursing		
	Project Start Date: 1st August 2016		End Date: 31st August 2017
	Proposed start and end-date of 3-year Research Passport:		
	Start Date: 1st July 2016		End Date: 1st July 2018
	NHS organisation(s):	Dept(s):	Proposed research activities:
	[REDACTED]	Nursing	Conducting individual interviews with registered nurses.
	[REDACTED]	Nursing	Conducting individual interviews with registered nurses.
			Manager in NHS organisation:

Section 3 – Declaration by Researcher <i>To be completed by Researcher</i>		
6.	Have you ever been refused an honorary research contract?	Yes <u>No</u>
	Have you ever had an honorary research contract revoked?	Yes <u>No</u>
	If yes to either question, please give details:	
I consent to the information provided as part of this Research Passport and attached documents being used, recorded and stored by authorised staff of the NHS organisations where I will be conducting research.		
Signed: Hannah Andrews <i>H Andrews</i>		Date: 28.06.15
When Sections 1-3 have been completed, the researcher should forward the form to the appropriate person to complete Section 4.		

Section 4 - Suitability of Researcher	
To be completed by researcher's substantive employer, e.g. line manager, or academic supervisor	
7.a	Will this person's research activity mean that they may be undertaking regulated activity with children and/or adults as defined in the Safeguarding Vulnerable Groups Act 2006, as amended (in particular by the Protection of Freedoms Act 2012)? (please use the Research Passport algorithm to make this judgement)
	Yes <input type="radio"/> No <input checked="" type="radio"/>
7.b	I am satisfied that the above named individual is suitably trained and experienced to undertake the duties associated with the research activities outlined in this Research Passport form.
	Signed:  Date: 29/7/15
	Name: PROFESSOR KATE SEERS Job Title: PROFESSOR
	Department and Organisation: WARWICK MEDICAL SCHOOL
	Address: COVENTRY CV4 7AL
	Tel No: 024 7615 0614 Email: kate.seers@warwick.ac.uk
	Managerial responsibility for the applicant:
When Section 4 has been completed, the researcher should forward the form to the appropriate person to complete Section 5.	
Section 5 - Pre-engagement checks To be completed by the HR department of the researcher's substantive employer or registry at place of study	
8.	Does the above named individual's research involve Regulated Activity with children and/or adults as defined in the Safeguarding Vulnerable Groups Act 2006, as amended (in particular by the Protection of Freedoms Act 2012)?
	Yes <input type="radio"/> No <input checked="" type="radio"/>
	If yes to the above, has the above named individual been checked against ISA barred lists for adults and/or children, as appropriate and have you received confirmation via the criminal record disclosure that the person is not barred from working with adults and/or children? (NB individuals who are barred from working with adults or children must not undertake a regulated activity in the NHS with the vulnerable group from which they are barred, and you must not submit a Research Passport form in such cases).
	Checked against: ISA Adults List? Yes <input type="radio"/> No <input checked="" type="radio"/> N/A
	ISA Children's List? Yes <input type="radio"/> No <input checked="" type="radio"/> N/A
	Can you confirm that a clear criminal record disclosure has been obtained for the above-named individual, with no subsequent reports from the individual of changes to this record? NB for Regulated Activity this must be an enhanced level criminal record check. For non-regulated activity, ensure the criminal record check is at the mandated level.
	Yes <input type="radio"/> No <input checked="" type="radio"/> N/A
	If yes, please provide details of the clear disclosure:
	Date of disclosure: Type of disclosure:
	Disclosure No.: Organisation that requested disclosure:
9.	Have the pre-engagement checks described below been carried out with regard to the above-named individual and is confirmation of the necessary checks, including any required satisfactory documentary evidence, available in the employing organisation's/place of study's records?
	• Employment/student screening:
	<input type="checkbox"/> ID with photograph Yes <input checked="" type="radio"/> No <input type="radio"/>
	<input type="checkbox"/> two references Yes <input checked="" type="radio"/> No <input type="radio"/>
	<input type="checkbox"/> verification of permission to work/study in the UK Yes <input checked="" type="radio"/> No <input type="radio"/>

<input type="checkbox"/> exploration of any gaps in employment	Yes No
• Evidence of current professional registration	Yes No N/A
• Evidence of qualifications	Yes No
• Occupational health screening / clearance	Yes No
Is the named individual on a fixed term contract or is the contract end imminent? Yes No	
Please indicate current contract end-date Date:	
Signed: 	Date: 13-08-15
Name: NICKY HARRIS	Job Title: HR ADVISER
Organisation:	Department: HR, UNIVERSITY OF
Address: WARWICK	
Tel No: 02476574874	Email: N.L.Harris@warwick.ac.uk
Please return the form to the researcher.	

Section 6 - Instructions to applicants To be completed by Researcher	
Please indicate which of the following documents are attached to this Research Passport:	
Current curriculum vitae, including details of qualifications, training and professional registration (please use the template C.V. at http://www.rdforum.nhs.uk/docs/template_cv.doc)	Yes No
Researcher's copy of criminal record disclosure. NB where research involves regulated activity with children and/or adults as defined in the Safeguarding Vulnerable Groups Act 2006, as amended (in particular by the Protection of Freedoms Act 2012), the disclosure must include confirmation of a check against the appropriate ISA barred list(s).	Yes No <u>N/A</u>
Evidence of occupational health screening / clearance	Yes No <u>N/A</u>
Appendix – List of projects and amendments	Appendix numbers: N/A

Please send the completed form and original documents to the Lead R&D office. The completed form and original documents will be returned to you. This package of documents will be used to validate your completed Research Passport form. You may then, and where relevant, provide the Research Passport to other NHS organisations.

You must inform all NHS organisations that have received this Research Passport of any changes to the information supplied above. Failure to do so may result in withdrawal of your honorary research contract or letter of access. As part of the quality control procedures for the Research Passport, random checks on the accuracy of the information held on this Research Passport may be made.

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Section 2 This section should be completed by HR in the Lead NHS organisation, only if additional checks are undertaken.			
The following additional checks have been completed:			
Having confirmed that the necessary additional pre-engagement checks have been completed, I am satisfied that the above named researcher is suitable to carry out the duties associated with their research activity outlined in this Research Passport.			
Signed:		Date:	
Name:		Job Title:	
Organisation:		Department:	
Email:			
Section 3 - For Office Use Only This section should be completed by the NHS R&D office that received the initial application. The NHS R&D office must countersign and date related photocopies of the documents. The grey section must be completed before the form is returned to the applicant.			
CV reviewed?	<input checked="" type="radio"/> Yes <input type="radio"/> No	Training?	Yes No <input type="radio"/> N/A
Evidence of qualifications?	<input checked="" type="radio"/> Yes <input type="radio"/> No	Appendix pages reviewed?	Numbers: <input type="radio"/> N/A
Professional registration details reviewed?	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Occupational health clearance reviewed?	Yes No <input checked="" type="radio"/> N/A
Criminal record disclosure reviewed?	Yes No <input checked="" type="radio"/> N/A	Date of disclosure:	Disclosure No:
For regulated activity as defined in the Safeguarding Vulnerable Groups Act 2006, as amended (in particular by the Protection of Freedoms Act 2012), did the criminal record disclosure confirm a satisfactory check against the appropriate ISA named list(s)?			Yes No <input checked="" type="radio"/> N/A
Enter Electronic Staff Record Number (if issued): <input checked="" type="checkbox"/>			
Confirmation of valid Research Passport:			
Project specific: <input checked="" type="checkbox"/> Three year: <input type="checkbox"/> Other End date Date: 30 Sept 2017			
Signed:		Date: 18/8/2015	
Name:		PATRICIA EMBURY	
NHS Organisation Name and contact details			
			
Date Honorary Research Contract/letter of access issued (delete as appropriate)			18.08.2015

